



STATE OF CONNECTICUT

OFFICE OF THE CHILD ADVOCATE

**INCARCERATED/DETAINED YOUTH - AN EXAMINATION OF CONDITIONS OF
CONFINEMENT**

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INTRODUCTION

The Office of the Child Advocate (OCA) is an independent state oversight agency directed by law to investigate and report on the efficacy of child-serving systems, investigate unexplained and unexpected child fatalities or critical incidents involving a child, review complaints of persons concerning the actions of any state or municipal agency providing services to children, and periodically review the facilities and procedures of any and all institutions or residences, public or private, where a juvenile has been placed by any agency or department.¹ The OCA was created in 1995 in response to the death of an infant involved with the Department of Children and Families (“DCF”).

In July, 2015, the OCA published an investigative report regarding conditions of confinement within two state-run juvenile correctional facilities, (i) the Connecticut Juvenile Training School for boys and the (ii) Pueblo Unit for girls – both facilities operated by DCF. The OCA’s investigation came in response to several complaints regarding the conditions for youth within those two programs. OCA’s report, published after an 18 month long investigation, included an extensive review of facility documents and video-tapes, and detailed findings regarding youths’ suicidal behavior, facilities’ restraint and seclusion practices, and deficient handling of allegations of abuse and neglect of youth within the facilities.

Subsequent to the publication of the OCA report, Governor Dannel Malloy announced his intention to permanently close the Connecticut Juvenile Training School by July 2018. The state’s Juvenile Justice Policy and Oversight Committee (“JJPOC”), created pursuant to Public Act 14-217, continues its efforts to support youth rehabilitation and ongoing improvement of public safety outcomes, with attention to diversion of low-risk youth, and delivery of a continuum of services and interventions for children with more complex needs. A critical component of the JJPOC’s work is to ensure provision of appropriate rehabilitative services to the highest risk youth in need of treatment in secure programs.

Conn. Gen. Stat. § 46a-13/(12) requires the OCA to report to the legislature regarding conditions of confinement for youth detained or incarcerated in the juvenile and adult criminal justice systems.² Accordingly, this report provides information regarding key issues affecting such youth, including: (1) suicidal behavior and suicide prevention; (2) use of force (restraint) and physical isolation (seclusion) of youth; (3) availability and utilization of clinical and rehabilitative programming; (4) access to educational programming for youth; (5) access to family visits and family therapy/engagement; and (6) child abuse/neglect reporting and prevention, in the following state-run juvenile and adult correctional facilities:

- Juvenile Detention Facilities (Bridgeport/Hartford) — Operated by the Judicial Branch’s Court Support Services Division (“CSSD”);
- Department of Correction Adult Correctional Facilities that House Minors — Manson Youth Institution (MYI) (boys) and York Correctional Institution (YCI) (girls);

¹ Conn. Gen. Stat. § 46a-13k *et. seq.*

² Section 46a-13/(12) provides that the Child Advocate shall “[p]repare an in-depth report on conditions of confinement, including, but not limited to, compliance with section 46a-152, regarding children twenty years of age or younger who are held in secure detention or correctional confinement in any facility operated by a state agency. Such report shall be submitted, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to children not later than March 1, 2017, and every two years thereafter.”

- Connecticut Juvenile Training School (“CJTS”) — Operated by the Department of Children and Families State-Run Juvenile Correctional Facility (Locked) for Boys Through April 2018 — Now Closed.³

The period under review (“PUR”) was July 1, 2016 through June 30, 2017, unless otherwise noted.

The OCA shared a draft of this Report with of the state agencies identified herein, including Court Support Services Division of the Judicial Branch, the Department of Correction and the Department of Children and Families. All agencies were given the opportunity to share with OCA any comments or concerns regarding the draft findings and recommendations.

Efforts have been made to incorporate or reference relevant feedback in the final report. Both CSSD and DOC leadership have affirmed their commitment to ongoing assessment of internal policies and practices necessary to ensure safety and well-being of youth in custody. This includes critical examination of data collection and review structures to ensure facility adherence to agency policies and reliable data reporting. As the state’s lead agency for child protection and children’s mental health, the Department of Children and Families has acknowledged their ongoing commitment to ensure the safety and well-being of youth served and willingness to partner, despite removal of responsibility for adjudicated youth from their statutory responsibilities and the closure of CT Juvenile Training School.

Given the scope of review, this Report addresses each of the six key issues, with relevant findings, by agency. The Report concludes with a series of issue specific recommendations for consideration by agency leadership and state policy makers.

EXECUTIVE SUMMARY

OCA’s review of conditions for youth incarcerated in state-run facilities confirms that children/youth of color remain disproportionately confined and incarcerated in Connecticut’s state-run facilities, and that the deeper youth go into the correctional system, the less likely they are to receive any developmentally appropriate programming and supports necessary to help youth change their behavior and successfully discharge back to their communities without committing new offenses.⁴

³ Despite its closure in May 2018, the analysis of CJTS remains in this Report as it offers relevant comparative information regarding the management and treatment of incarcerated youth.

⁴ Connecticut correctional facility admission data continues to show that incarcerated youth are disproportionately African American/Black and Hispanic. Research shows the disproportionate minority contact in the justice system is both a national and a local problem: Racial and ethnic minorities are often disproportionately represented in the juvenile justice system. The observed disproportionality cannot be fully explained by differences in delinquent behavior across racial and ethnic groups. Disparities were found in system processing of minority youth, even when controlling for social and legal background variables at various points of juvenile justice systems across the country. A 2017 report by, commissioned by, found that disparities in system process of minority youth in Connecticut continues to affect rates of detention and incarceration for children of color. Addressing racial inequities in the juvenile and criminal justice system must be an urgent and core priority for all stakeholders. Source: Spectrum Associates Market Research, “An Assessment of Disproportionate Minority Contact in Connecticut’s Juvenile Justice System,” (Nov. 17, 2017), submitted to the Office of Policy and Management, available on the web at: https://www.ct.gov/opm/lib/opm/cjppd/cjjyd/jjydpublishations/ct_2017_dmc_assessment_study_final_report.pdf

Children/youth, particularly boys with the most complex needs, who are incarcerated in the adult criminal justice system, are the most likely to lose meaningful access to education, rehabilitative services, visits with family, even the ability to purchase hygiene products or extra food, if they are deemed a risk to the general youth prison population. These boys, the children/youth who often need the most help--are counterintuitively the most likely to go without help in the adult prison system. They are the most likely to be placed in repeated or prolonged physical and social isolation while incarcerated—a practice that research consistently shows has devastating impact for youth, increasing their risk of mental health deterioration and suicide.

OCA also found that while some policies regarding provision of care and treatment to incarcerated youth in the juvenile justice system are developmentally appropriate and progressive, attention to facility operations and compliance with agency/s policies remains an urgent priority for further review by stakeholders and agency leaders. OCA recognizes the comprehensive reform work that state agencies are engaged in to support better outcomes for juveniles and their communities, with continued success in diverting lower-risk youth to community based services and away from detrimental engagement with the criminal justice system. The OCA is encouraged by the DOC's recent discussions with the Vera Institute of Justice to review its policies, procedures, and practices for detained youth.

However, OCA also found that throughout the child-serving juvenile and adult correctional system, substantial work remains to support better outcomes for the highest-risk youth. A determination must be made by policy makers and agency leaders as to the supports that incarcerated youth require, the work that needs to be done with them and their loved ones, and how such work can be most effectively accomplished in the context of the facilities that confine youth and the communities they come from and will return to.. The state's reform work must also include development of a transparent framework for ensuring the provision of effective rehabilitative programming for incarcerated youth. Finally, the state needs to consider whether conditions can even be created for youth in adult facilities that will promote effective rehabilitation and public safety goals.

OCA found that, with regard to incarcerated youth, there are few, and in some cases, no universal standards in Connecticut law or agency practices regarding a) the provision of mental health services; b) the use of isolation or force; c) strategies to prevent or respond to youth suicidal/self-harming behavior; d) provision of educational services; e) family engagement and relationship building; or even f) prevention and reporting of child abuse and neglect.

OCA finds that the lack of a standard, developmentally informed approach for incarcerated youth and the lack of a transparent framework for publishing information regarding the efficacy of secure care is highly problematic for the state's twin goals for youth incarceration--

“Adult-style prisons that emphasize confinement and control are devoid of the essentials required for healthy adolescent development---engaged adults focused on their development, a peer group that models prosocial behavior, opportunities for academic success, and activities that contribute to developing decision-making and critical thinking skills. At the same time, these facilities provide too many of the elements that exacerbate the trauma that most confined youth already experienced and reinforce poor choices and impulsive behavior. Maltreatment is endemic and widespread.” McCarthy, Patrick, Vincent Schiraldi, and Miriam Shark. *The Future of Youth Justice: A Community-Based Alternative to the Youth Prison Model*. New Thinking in Community Corrections Bulletin. Washington, D.C.: U.S. Department of Justice, National Institute of Justice, 2016. NCJ 250142, available at <https://www.ncjrs.gov/pdffiles1/nij/250142.pdf>.

promoting youth rehabilitation and improving public safety, in part due to the lack of information regarding what help youth actually receive while incarcerated and whether that help is adequate or effective. The lack of uniform standards can also place youth and facility staff at risk of harm, and may result, in some cases, in violations of state and federal law and deeply concerning conditions of confinement, particularly for minors in the adult prison system.

METHODOLOGY

This investigation involved review of statistical and descriptive information provided by the Department of Correction (“DOC”), the Department of Children and Families (“DCF”),⁵ and the Connecticut Judicial Branch Court Support Services Division (“CSSD”), including record reviews, interviews, observations, and review of the literature. More specifically, the OCA undertook the following to ensure an accurate understanding of conditions of confinement for youth in Connecticut facilities:

- Multiple meetings and correspondence with representatives from CSSD, DOC, and DCF to discuss issues and information developed in conjunction with this report.
- Review of child-specific education, mental health, and custodial records from CSSD, DOC, and DCF.
- Site visits to facilities run by CSSD, DOC, and DCF.
- Review of youth surveys for incarcerated youth.
- Meetings with incarcerated youth.
- Examination of applicable state and federal statutes and regulations governing the use of restraint and seclusion for minors, and the provision of education and mental health services to children in state custody.
- Review of federal reports, technical assistance guides, research and literature regarding conditions of confinement for incarcerated youth, and best/promising practices for youth confined in juvenile and adult correctional facilities.
- Review of facility policies, procedures, and data regarding the conditions of confinement outlined in this report from CSSD, DOC, and DCF:

Suicidal Behavior and Suicide Prevention

- A copy of the agency’s/facility’s suicide prevention policy, guidelines, protocols, and any audits that have been conducted in the last year (July 1, 2016 through June 30, 2017).
- Number of youth confined within the facility or facilities who have had suicidal behaviors in the past year (July 1, 2016 through June 30, 2017), broken down by type of behavior (or safety monitoring).

Use of Force and Isolation-Restraint, Seclusion and Restrictive Housing

- Facility policies regarding use of restraint and seclusion/room confinement/cell confinement.

⁵ The OCA has electronic access to DCF case files and reports, which allows the OCA to meet its statutory responsibilities, and for purposes of this report, provided a more precise lens into CJTS than the other facilities reviewed in this Report.

- Description of how data is kept and reviewed by agency personnel regarding use of restraint and seclusion/room confinement/cell confinement.
- Description of any programs, trainings, and interventions to address use of restraint and seclusion/room confinement/cell confinement.
- Facilities' training schedule regarding restraint/use of force and seclusion, information regarding whether all staff are trained, and how often trainings occur.
- Physical restraint data for a 6 month period (January 1st, 2017 - June 30th, 2017), including the number of children or percentage of the youth population who experienced physical restraint.
- Mechanical restraint data for a 6-month period (January 1st, 2017 - June 30th, 2017), including number of children or percentage of youth population who experienced mechanical restraint. Data on mechanical restraint utilization as it applies to children who are restrained within the facility due to an incident, and mechanical restraints used inside and outside the facility for transport.
- Chemical restraint policies and utilization data for the 6 month period (January 1st, 2107- June 30, 2107)
- Seclusion/room confinement/cell confinement/ data facility-wide for 6 months (January 1st, 2017 - June 30th, 2017), including number of children or percentage of youth population who experienced such confinement and the average and range of duration for utilization of seclusion/room confinement/cell confinement.

Access to Mental Health Treatment

- Description of all clinical/mental health services that are currently available to confined/detained youth.
- Description of utilization of such services by confined/detained youth between January 1, 2017 and June 30, 2017.
- Clinician to client ratio; hours clinicians are available, and weekly schedule, including weekends.
- Processes by which the facility identifies and evaluates youth's need for clinical services.

Access to Educational Programming

- Description of current educational services offered, including policies and protocols for the identification of students with special education needs; availability of special education and related services, including transition services; hours of services available.
- Attendance histories for students served between July 1, 2016, and June 30, 2017, including instances of suspension, duration of suspension, removal from school programming, or instances where children are not permitted to attend school for safety reasons.

Abuse/Neglect and Mandated Reporting

- Policies and training for staff regarding compliance with state laws governing mandated reporting of abuse and neglect.

Family Contact/Family Engagement

- Facility's policies regarding family visitation; including visitation hours and other opportunities for visitation.

- Number/percentage of youth who have had family visits, frequency of visits, and total number in the past 6 months per youth. (January 1st, 2017-June 30th 2017)
- Availability of family therapy and the number/percentage of youth who have had family therapy sessions, the frequency of the therapy, and total number in 6 months per youth (January 1st, 2017-June 30th, 2017)

CRITICAL ISSUES IMPACTING INCARCERATED/DETAINED YOUTH

There are a number of critical issues that impact youth who are incarcerated/detained, including, but not limited to: (1) suicidal behavior and suicide prevention; (2) use of force (restraint) and physical isolation (seclusion) of youth; (3) availability and utilization of clinical and rehabilitative programming; (4) access to educational programming for youth; (5) child abuse/neglect reporting and prevention and (6) access to family visits and family therapy/engagement, in the state-run juvenile and adult correctional facilities that were part of OCA's review.⁶

Incarcerated youth are “emerging adults” who are at an important stage of their emotional and intellectual development. Science confirms that the adolescent brain is not fully developed until far into the twenties, and that the last features of the brain to develop are those that control judgment, decision-making and proper understanding of the consequences of actions. “Emerging adults have the highest recidivism rates of any age group, again both nationally and in Connecticut. Yet this is also an age of opportunity – a time when arrest rates begin to decline and when the life trajectory of young people can be influenced for the better.”⁷ Researchers agree that these “emerging adults” are at a critical development period. “Emerging adults,” a term first coined in 2000 by psychologist and author Jeffrey Arnett at Clark University, is a term that has become increasingly adopted in the criminal justice arena. The term invokes a critical developmental period: the transition from a child who is dependent on parents or guardians for supervision and guidance (as well as emotional and financial support) into a fully mature, independent adult who engages as a productive and healthy member of society.⁸ The issues examined in this report have a profound effect on the life of the incarcerated youth, and the lack of clear guidelines and adherence to national standards compounds the difficult time served by these youth and contributes to the lack of recovery for such youth.

A. SUICIDAL BEHAVIOR AND SUICIDE PREVENTION

According to the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention (“OJJDP”):

⁶ These issues disproportionately affect racial and ethnic minorities in the justice system and is both a national and a local problem. The observed disproportionality cannot be fully explained by differences in delinquent behavior across racial and ethnic groups. Disparities were found in system processing of minority youth, even when controlling for social and legal background variables at various points of juvenile justice systems across the country. A 2017 report found that disparities in system process of minority youth in Connecticut continues to affect rates of detention and incarceration for children of color. Addressing racial inequities in the juvenile and criminal justice system must be an urgent and core priority for all stakeholders. Available at: Spectrum Associates Market Research, “An Assessment of Disproportionate Minority Contact in Connecticut's Juvenile Justice System,” (Nov. 17, 2017), submitted to the Office of Policy and Management, available on the web.

⁷ Harvard Kennedy School, Malcolm Wiener Center for Social Policy, *Report, Public Safety and Emerging Adults in Connecticut: Providing Effective and Developmentally Appropriate Responses for Youth Under Age 21*, By Lael Chester and Vincent Schiraldi (December 28, 2016).

⁸ Id.

Suicide is the leading cause of death among youth in confinement. A study of youth in detention found one in ten had thought about killing themselves in the previous 6 months. Fewer than half of the youth with recent suicidal thoughts had told anyone about them. Rates are likely even higher among youth who are deeper in the system. Suicidal ideation is higher in post-adjudication youth than in pre-adjudication youth, with some studies showing that suicidal ideation for post-adjudication youth in secure facilities was 51% (past year) and 58% (life time).

When working with youth who have the risk factors below, line staff should be alert to the possibility of suicidal thoughts or behavior: (i) previous suicidal behavior; (ii) mental Health disorders; (iii) substance use disorders; (iv) aggressive or violent behavior; (v) family factors (e.g., suicide, mental illness, substance use among parents or caregivers; parental absence; lack of support; abuse or neglect; family conflict or domestic violence); (vi) poor social skills or few friends; (vii) stressful life events (e.g., legal or discipline problems; incarceration; isolation from peers in a facility; lengthy time in a room or cell; prolonged stay in a juvenile justice facility); (viii) childhood abuse or neglect; and (ix) exposure to someone else's suicide.

Because most incarcerated youth often have three, four, or even all of the listed suicide risk factors, in addition to the stress of being detained or incarcerated, and restricted access to their typical self-injurious coping skills (cigarettes, alcohol, other drugs, fighting, running away) and any positive influences (family, educators, intimacy, community) – **all youth in custody should be viewed as at risk for killing themselves.** The majority of youth who have died by suicide in juvenile justice facilities were not on any type of suicide precautions at the time of his/her death.

Facility suicide hazards include: low number of staff per youth requiring supervision; over-reliance on isolating juveniles; easily reached protrusions or projections in rooms; access to psychotropic medication; unit or cottage layout and routine and predictable monitoring.⁹

Research shows that youth who are deeper in the justice system have higher prevalence rates of suicidal ideation and behavior. “Youth sampled during stays in post-disposition secure facilities appear to have the highest prevalence rates of suicidal ideation and attempts.” Girls have higher prevalence rates than boys.¹⁰

The risk of suicide for incarcerated/detained youth is a national problem. “On an average day [nationwide], approximately 61,000 youth are in custody in detention centers (OJJDP, 2013). [Researchers] estimate that as many as 22,000 detainees have considered suicide, 17,900 have attempted suicide at least once, and 5,200 have made a recent attempt.” Juvenile justice professionals and researchers must collaborate to increase the safety and improve the mental health of delinquent

⁹ National Institute of Corrections and OJJDP: *The Desktop Guide to Quality Practice for Working with Youth in Confinement* (2014), (hereinafter OJJDP/NIC Guide) available on the web: <https://info.nicic.gov/dtg/sites/info.nicic.gov.dtg/files/DesktopGuide.pdf>.

¹⁰ Teplin, L., Stokes, M., et al., *Suicidal Ideation and Behavior in Youth in the Juvenile Justice System: A Review of the Literature*, Jour. Correct. Health Care (July 2015).

youth. The competent and comprehensive assessment of suicide risk and timely interventions will prevent untimely deaths.”¹¹

B. USE OF FORCE AND ISOLATION – SECLUSION AND RESTRICTIVE HOUSING

Rehabilitation for incarcerated youth needs to be a priority. Treatment programs should include access to substance abuse and mental health, support for other risk indicators like social isolation, and efforts to reduce seclusion and restrictive housing need to be a priority.

Solitary Confinement/Physical Isolation of Incarcerated Youth

Youth experience symptoms of paranoia, anxiety and depression even after very short periods of isolation. Confined youth who spend extended periods isolated are among the most likely to attempt or actually commit suicide. The use of force and/or isolation can result in exacerbated behavioral issues in youth who are incarcerated. Without appropriate interventions, force and/or isolation are merely quick fixes to temporarily contain behavioral issues that are not really being managed or treated, but rather ignored.

One of the first obstacles to changing the practice of placing youths in isolation is that there is no nationally agreed on definition of isolation and no national publication of standardized, uniform, and comparable isolation data. The Council of Juvenile Correctional Administrators (“CJCA”) focuses on reducing the use of isolation with minors and defines isolation as: any time a youth is physically and/or socially isolated for punishment or for administrative purposes.

A recent report commissioned by the U.S. Department of Justice acknowledges the conflicting terms used to describe the separation of inmates from general population, though DOJ documents define “administrative segregation” similarly to new Connecticut law as a practice “used to separate those deemed to pose a significant threat to institutional security from the general population,” either due to “patterns of disruptive behavior, security threat group identifications, or designation as high-risk inmates.”¹²

The DOJ report notes that solitary confinement practices in adult correctional systems vary, “but a defining feature of current solitary confinement practice is the isolation of inmates for 22-24 hours a day in a small cell, with minimal contact with others, in areas of the facility designed for the purpose of restricting inmates’ movement. Other distinct features of current solitary confinement practices include reduced natural light; limited lighting; little to no access to programming, classes, reading, radio and television as well as restrictions placed on visitation from friends and family.”¹³

Experts distinguish between solitary confinement and a temporary “time out,” which can be a necessary and reasonable measure to defuse a dangerous situation where a youth is engaged in behavior that is harmful to himself and others.

The OJJDP/NIC Guide author/s has recommended that “[g]iven the harm imposed and increased potential for legal liability, facilities should strictly limit or eliminate altogether the use of isolation

¹¹ Id.

¹² Id. at 5.

¹³ Id.

practices.”¹⁴ Guidance commissioned by the Department of Justice provides that “decreasing, and eventually eliminating, the isolation and restraint of youth housed in juvenile and adult facilities typically requires:

- 1) Significant staff training;
- 2) Practical coaching on the units;
- 3) Accountability for staff behavior.”¹⁵

In 2012, a task force appointed by the U.S. Attorney General concluded, “Nowhere is the damaging impact of incarceration on vulnerable children more obvious than when it involves solitary confinement. . . . Juveniles experience symptoms of paranoia, anxiety, and depression even after very short periods of isolation. Confined youth who spend extended periods isolated are among the most likely to attempt or actually commit suicide. One national study found that among the suicides in juvenile facilities, half of the victims were in isolation at the time they took their own lives, and 62 percent of victims had a history of solitary confinement.”¹⁶

Connecticut law does not provide a clear definition of solitary confinement. Across the country, juvenile and criminal justice experts acknowledge the lack of consistency in defining the practice of physically isolating incarcerated youth. Experts agree regarding the potentially significant harms associated with physically and socially isolating any juvenile in an enclosed space or room other than for the purpose of sleeping or as a temporary response to behavior that threatens immediate harm to the youth or others.¹⁷ There have been national efforts to address physical isolation in correction facilities and lean heavily toward elimination all such isolation.

Four different Connecticut statutes address the use of restraint and/or seclusion with, respectively, 1) persons at risk (youth in DCF facilities); 2) students; 3) youth in CSSD detention facilities; and 4) individuals incarcerated by the DOC. Those statutes unique to the particular facility will be discussed within those facility sections.

National Standards Regarding Physical Isolation in Correctional Facilities

The National Commission on Correctional Health Care (“NCCHC”)

The National Commission on Correctional Health Care (“NCCHC”) issued a 2016 Position Statement on Solitary Confinement. NCCHC defines solitary confinement as the housing of an adult or juvenile

¹⁴ OJJDP/NIC Guide, *supra* N. 9, Ch. 5, Umpierre, M., “Rights and Responsibilities of Youth, Facilities, and Staff,” pg. 13.

¹⁵ Id., Ch. 11, Boesky, L., “Mental Health,” pg. 44.

¹⁶ National Commission on Correctional Health Care, 2016 Position Statement on Solitary Confinement (Isolation).

¹⁷ Council of Juvenile Correctional Administrators Toolkit: Reducing the Use of Isolation (Mar. 2015), available on the web at: <http://cjca.net/attachments/article/751/CJCA%20Toolkit%20Reducing%20the%20Use%20of%20Isolation.pdf>; See also National Institute of Justice, Frost, N. and Monteiro, C., “Administrative Segregation in U.S. Prisons,” (March 2016), pg. 3-4, available on the web at: <https://www.ncjrs.gov/pdffiles1/nij/249749.pdf> (“Within correctional contexts, the terms used to describe segregation policies and practices vary greatly across jurisdictions. Although they represent conceptually distinct practices, it is difficult to separate the literature on disciplinary segregation from the literature on administrative segregation because researchers have tended to study solitary confinement without carefully distinguishing the various types of segregated restrictive housing units.”)

with minimal meaningful contact with others and with access to few or no programs.¹⁸ The NCCHC, like other national organizations, acknowledges that terminology varies by jurisdiction, and that solitary confinement may be referred to by a number of terms, including isolation; administrative, protective, or disciplinary segregation; security housing; and restrictive housing units.¹⁹ The NCCHC notes that solitary confinement is used for a variety of reasons, including discipline and safety concerns, leading to the use of restrictive housing for known or suspected gang members.²⁰

Citing national and internal organizations’²¹ concern regarding the harms created by use of solitary confinement for any individual, the NCCHC 2016 Position Statement contends that “prolonged (greater than 15 consecutive days) solitary confinement is cruel, inhumane, and degrading treatment, and harmful to an individual’s health;” and that “Juveniles, mentally ill individuals, and pregnant women should be excluded from solitary confinement of any duration.” The NCCHC further states that “[h]ealth staff must not be involved in determining whether adults or juveniles are physically or psychologically able to be placed in isolation.”

¹⁸ NCCHC Policy Statement on Solitary Confinement in Correctional Facilities, available on the web at: <https://www.ncchc.org/solitary-confinement>.

¹⁹ *Id.*

²⁰ *Id.*

²¹ The American Psychiatric Organization, the World Health Organization, the United Nations.

**Juvenile Detention
Alternatives Initiative
Standards for Room
Confinement**

The Juvenile Detention Alternatives Initiative (“JDAI”), established by the Annie E. Casey Foundation to promulgate standards in support of improved conditions of confinement in juvenile detention centers provides the following with respect to the use of physical and social isolation of juveniles:

1. Isolation should never be used other than for brief periods to prevent immediate risk of physical harm;
2. Isolation can never be used for longer than 4 hours;
3. Isolation can only be used if staff provide continuous one-on-one crisis intervention and observation;

Any youth who cannot be calmed within 4 hours must be transferred for mental health evaluation and intervention.

**Performance-Based
Standards for Juvenile
Correctional Facilities
 (“PBS”)**

“PBS standards are clear: isolating or confining a youth to his/her room should be used only to protect the youth from harming himself or others and if used, should be brief and supervised. Any time a youth is alone for 15 minutes or more is a reportable PBS event and is documented;” and “isolation . . . should not be used as punishment.”

**American Correctional
Association, Performance-
Based Standards for
Juvenile Correctional
Facilities**

“In the very rare event that room confinement lasts for longer than 24 hours, the American Correctional Association standards require a review every 24 hours by a facility administrator or designee who was not involved in the incident; and that room confinement for any offense should not exceed 3-5 days.”

Dr. Robert Kinscherff, a mental health program consultant hired by DCF in 2014-15 to assist with review of programming and conditions of confinement at CJTS, observed that “in a trauma-informed model, the need to use restraint or seclusion is viewed as a clear intervention failure and so considerable effort is given following the episode to assess the process leading to restraint and seclusion with the individual and the staff involved.”²²

Lindsay Hayes, an expert in juvenile suicide prevention in correctional facilities, cautions, “[a]lthough room confinement remains a staple in most juvenile facilities, it is a sanction that can have deadly consequences.... more than 50 percent of all youths’ suicides in juvenile facilities occurred while young people were isolated alone in their rooms and more than 60 percent of young people who committed suicide in custody had a history of being held in isolation.”²³

There are no standard definitions of restraint or seclusion contained in Connecticut law that apply to youth served by all

agencies. For example, the state law that prohibits use of prone/face-down restraint of students due to concerns over airway restriction and chest compression is not applicable to incarcerated youth. Both prone and chemical restraints are utilized with youth in DOC custody.

²² Kinscherff, R., “*Strategic Review of CJTS/Pueblo Girls Unit Program, Policies and Practices*,” (“Kinscherff Report”), (2015), pg. 17-18, available on the web at: <https://www.cga.ct.gov/2015/kiddata/od/08.12%20Forum%20%20Final%20Report%20on%20CJTS%20and%20Pueblo%20by%20Dr%20Kinscherff.pdf>.

²³ Lindsay M. Hayes, *Juvenile Suicide in Confinement: A National Study*. 2004.

Use of Chemical Agents on Incarcerated/Detained Youth

A recent article from the Juvenile Justice Information Exchange²⁴ indicates that as of 2018 there were only six (6) states that allowed juvenile correctional officers to carry pepper spray.²⁵ Thirty-five (35) states have banned pepper spray in juvenile facilities.²⁶

A fact sheet regarding the use of chemical agents on juveniles authored by the Center for Children's Law and Policy ("CCLP")²⁷ in 2012 recommends a prohibition on the use of chemical agents on children due to potential health risks and the potential for misuse by staff. The CCLP cites research published in the British Medical Journal which noted the ill effects of chemical agents in confined spaces and areas with poor ventilation.²⁸ The CCLP identified several states that have taken action to prohibit chemical agent use on juveniles.²⁹

OCA sought additional information from physicians at Yale School of Medicine regarding the impact of chemical agents such as pepper spray on minors. OCA was provided with research literature indicating that pepper spray and other irritants have been associated with various health risks and complications such as pulmonary edema and asthma.³⁰ According to literature provided to OCA by a physician at Yale, pepper spray and similar irritants, when inhaled, produce "a sensation of chest constriction with dyspnea, gagging and burning of the respiratory tract."³¹ The effects of tear agents are generally considered transient and may dissipate quickly once removed from the source, but sensitivity to irritants is "individual and age-dependent."³²

According to the Council of Juvenile Correctional Administrators:

[Pepper spray's] use has been shunned by juvenile correctional agencies because of the harm it causes to youth and the negative impact on staff-youth relationships, the key to successful juvenile rehabilitative programming. Very few states authorize its use [in juvenile

²⁴ The Juvenile Justice Information Exchange (JJIE) is a publication covering juvenile justice and related issues nationally. The JJIE is based at Kennesaw State University. <https://jjie.org/>

²⁵ Almasi, Aya, *California Corrections Board Approves Limits to Pepper Spray, No Change to Staff Ratios*, Feb. 14, 2018, JJIE, article available on the web at <https://jjie.org/2018/02/14/california-corrections-board-approves-limits-to-pepper-spray-no-change-to-staff-ratios/>, article cites California, Illinois, Indiana, Minnesota, South Carolina, and Texas as permitting use of chemical agents on minors in juvenile justice facilities.

²⁶ *Id.*

²⁷ Center for Children's Law and Policy, *Chemical Agents in Juvenile Facilities*, (May 2012), available on the web at: <http://www.cclp.org/wp-content/uploads/2016/06/Fact-Sheet-Chemical-Agents-Final-5-14-12.pdf>.

²⁸ *Id.* citing Pierre-Nicholas Carron & Bertrand Yersin, *Management of the Effects of Exposure to Tear Gas*, 338 BRITISH MED. J. 1554, 1556 (2009).

²⁹ *Id.* referencing, among others, 1) The Louisiana Office of Juvenile Justice barred chemical agents in its facilities in 2007; 2) The Florida state legislature, in 2006, required the Department of Juvenile Justice to adopt policies that "prohibit the use of aerosol or chemical agents;" 3) New Jersey, in 2005, amended its administrative code to clarify that the use of chemical agents is not allowed in juvenile detention facilities; 4) New Hampshire, in 2010, passed a statute prohibiting the "intentional release of noxious, toxic, caustic, or otherwise unpleasant substances near a child for the purpose of controlling or modifying the behavior of or punishing the child" in a range of settings, including schools, group homes, shelters, detention centers, and commitment facilities."

³⁰ Upper airway problems may include laryngeal edema and stridor. Significant eye injuries may also occur, including corneal epithelial injury and kerato-conjunctivitis. Research literature provided via correspondence from Carl Baum, M.D., FAAP, FACMT, Professor of Pediatrics and of Emergency Medicine, Yale School of Medicine to the OCA, on file with OCA.

³¹ *Id.* citing article on Toxed.com.

³² *Id.*

correctional programs] and in the states that allow its use in policy, most prohibit the use except as a last resort and with many conditions and few facilities put it into practice³³

Connecticut law contains no statutory prohibition on the use of chemical agents on minors, even those with respiratory conditions.

C. ACCESS TO MENTAL HEALTH TREATMENT

A high percentage of incarcerated/detained youth may present with signs and symptoms of mental health disorders, including symptoms of extensive trauma exposure. A significant percentage of youth incarcerated in the juvenile and adult criminal justice systems have experienced trauma and have associated behavioral health and mental health treatment needs.³⁴ National research estimates that a significant percentage of such children are suffering from symptoms of trauma exposure—personal and community violence, abuse and neglect, and extreme deprivation. Researchers have found that many justice-involved youth enter confinement with histories of significant depression, anxiety and suicidality.³⁵

D. ACCESS TO EDUCATIONAL PROGRAMMING

Federal law provides that any state agency involved in the provision of special education and related services to students in correctional facilities must ensure the provision of a Free Appropriate Public Education (FAPE), even if other agencies share that responsibility. Connecticut law provides that education in the detention centers is the responsibility of the local school district. Bridgeport Public Schools provides educational services to the Bridgeport detention center, and Hartford Public Schools contracts with a community-based provider to deliver education services in the Hartford detention center. As discussed later in this Report, OCA found that local school districts responsible for educating children/youth in detention facilities incorrectly reported that no children/youth were suspended from detention school programs — data shows that children are subject to removals from school.

United States Departments of Education and Justice - Joint Guidance for Meeting Educational Needs of Incarcerated Youth

In December 2014, the United States Departments of Education and Justice published joint guidance for State Education Agencies and State Attorneys General on meeting the educational needs of incarcerated children/youth.³⁶ This guidance stated that providing high quality correctional³⁷ education to children/youth “is one of the most powerful—and cost-effective—levers we have to

³³*Pepper Spray in Juvenile Facilities*, CJA, available on the web at: <http://cjca.net/attachments/article/172/CJCA.Issue.Brief.OCSpray.pdf>.

³⁴ OJJDP, “*Meeting the Educational Needs of System-Involved Youth*,” (Dec. 2014), available on the web at: <https://www.ojjdp.gov/programs/commitment120814.pdf> at 2-3 *citing* the Attorney General’s Advisory Committee on American Indian/Alaska Native Children Exposed to Violence: Ending Violence so Children Can Thrive, November 2014.

³⁵ Teplin, L., Stokes, M., et al., *Suicidal Ideation and Behavior in Youth in the Juvenile Justice System: A Review of the Literature*, Jour. Correct. Health Care (July 2015)

³⁶ <https://www.ojjdp.gov/programs/letter120814.pdf>

³⁷ The U.S. Departments of Education and Justice’s Dear Colleague letter to states provided no definition of correctional facility but indicated that its reference therein referred to “juvenile justice facilities, detention facilities, jails, and prisons where students with disabilities are, or may be confined.” Letter at 1, N. 1.

ensure that youth are successful once released and are able to avoid future contact with the justice system.”³⁸ The guidance recommended that facilities also ensure provision of post-secondary correctional education, noting that such services can be supported by Federal Pell Grants, as a measure to reduce recidivism.³⁹

The Guidance included a Dear Colleague letter to states, which emphasized that “[a]bsent a specific exception, all [Individuals with Disabilities Education Act] protections apply to students with disabilities in correctional facilities.”⁴⁰ The guidance noted that “students with disabilities represent a large portion of students in correctional facilities” and it “appears that not all students with disabilities are receiving the special education and related services to which they are entitled.”⁴¹ The guidance referred to numerous challenges such as “overcrowding, frequent transfers ..., lack of teachers, inability to address gaps in students’ education, and lack of collaboration with the [local school district]” as contributing to the problem.⁴²

The Dear Colleague letter included the following recommendations:

- Every agency at any level of government that is involved in the provision of special education and related services to students in correctional facilities must ensure the provision of a Free Appropriate Public Education (FAPE), even if other agencies share that responsibility.
- States must have interagency agreements or other methods for ensuring interagency coordination so that it is clear which agency or agencies are responsible for providing or paying for services necessary to ensure FAPE for students with disabilities in correctional facilities.
- States and their public agencies must have child-find policies and procedures in place to identify, locate, and evaluate students who in correctional facilities who may have a disability under the IDEA and need special education and related services. This responsibility includes students who have never been identified as having a disability prior to their incarceration.
- Students suspected of having a disability who need special education and related services must be evaluated, subject to applicable parental consent requirements, in a timely manner, even if the student will not be in the facility long enough to complete the evaluation.
- When a student with an IEP transfers to a correctional facility, the responsible public agency must provide the student with FAPE through services that are comparable to those described in these student’s IEP until that agency either adopts the previous agency’s IEP or develops and implements a new IEP for the student.
- The IDEA requirements related to least restrictive environment (LRE) apply to the education of students with disabilities in correctional facilities. IEP teams or placement teams must make individualized placement decisions and may not routinely place all

³⁸Id. pg. 1

³⁹Id. pg. 2.

⁴⁰Id. pg 1.

⁴¹Id. pg. 2, citing evidence suggesting that “proper identification of students with disabilities, and the quality of education services offered to students in these settings is often inadequate.”

⁴²Id.

incarcerated students with disabilities in classes that include only students with disabilities, even if this means creating placement options or using other arrangements, to the maximum extent appropriate to the student's needs.

- Public agencies must comply with all applicable IDEA secondary transition requirements to facilitate eligible students' movement from secondary education in the correctional facility to appropriate post-school activities.
- IDEA due process protections apply to students in correctional facilities and to their parents.
- Any exclusion from the classroom is particularly harmful for students with disabilities in correctional facilities. In general, even in the presence of disciplinary concerns, because correctional facilities are run by public entities, their obligation to ensure that special education and related services are provided to eligible students with disabilities continues.

A student with a disability in a correctional facility who violates a code of student conduct is entitled to the protections in the IDEA discipline procedures that must be afforded to all students with disabilities. These protections apply regardless of whether a student who violates a code of student conduct is subject to discipline in the facility or removed to restricted settings, such as confinement to the student's cell or "lock down" units.

In any event, a removal from the current educational placement that results in a denial of educational services for more than 10 consecutive school days, or a series of removals that constitute a pattern that total more than 10 school days in a school year is a change in placement, which, in turn, requires a manifestation determination under the IDEA. Such a change in placement requires the public agency to a) provide services to the student to enable the student to continue to participate in the general education curriculum and to progress toward meeting the goals in the student's IEP; and (b) conduct, as appropriate, a functional behavioral assessment and provide behavioral intervention services and modifications that are designed to address the behavioral violation so that it does not recur.

E. ABUSE/NEGLECT AND MANDATED REPORTING

The law provides that among others, a mandated reporter is "any person paid to care for a child in any public or private facility, child care center, group child care home or family child care home licensed by the state," "any employee of the Department of Children and Families," any "mental health professional," "physician," "psychologist," "nurse," "school employee," or a juvenile or adult probation officer. Most, but not all employees/contractors in youth-serving facilities are mandated reporters.

State law provides that certain individuals, due to the nature of their profession and interaction with minors, are mandated to report to DCF or law enforcement when they have "reasonable cause to suspect or believe that any child under the age of eighteen years (a) has been abused or neglected..., (b) has had non-accidental physical injury, or injury which is at variance with the history given of such injury... or (c) is placed at imminent risk of serious harm."⁴³ The law requires that suspicion must be reported to DCF or local law enforcement within 12 hours, and a written follow up report must be submitted within forty-eight hours.⁴⁴ Any person who fails to make a report as required by law "shall

⁴³ Conn. Gen. Stat. § 17a-101.

⁴⁴ Conn. Gen. Stat. § 17a-101c.

be guilty of a class A misdemeanor,” or a felony if the violation of law is deemed “willful or intentional or due to gross negligence.”

There is no state law that requires youth-serving agencies to publish information regarding concerns of abuse or neglect or associated corrective actions and no agency routinely reports such information.

F. ACCESS TO FAMILY CONTACT /FAMILY ENGAGEMENT

The U.S. Department of Justice’s Office of Juvenile Justice and Delinquency Prevention (“OJJDP”) survey of families whose children are or have been in the juvenile and adult criminal justice systems reveals wide-spread frustration and despair over families’ concern that they are not a meaningful part of the legal and treatment decisions that affect their children’s lives, and that they are treated by professionals in a way that made them feel “ashamed and guilty.” According to listening sessions conducted by the OJJDP in 2011, families often feel disconnected from the judicial and legal decision-making process.⁴⁵ The framework for visitation and family engagement with incarcerated youth varies by agency. Many incarcerated youth do not receive visits. Many youth do not receive family therapy, though most youth are released to a family member.

Families reported that they lacked information to help their children, and that they were treated by professionals in a way that made them feel “ashamed and guilty.”⁴⁶ The OJJDP followed publication of its listening sessions with a policy statement regarding the need to actively engage system-involved youth and their families in planning and decision-making that affects their lives through the development of juvenile justice practices and policies, but also through direct involvement in the development of each child’s treatment program while incarcerated.⁴⁷ According to the OJJDP’s survey:

- 86% of family members reported they would like to “be more involved in their child’s treatment while he or she is confined in a correctional facility or not her residential placement.”
- 75% of family members surveyed reported that they faced “serious impediments to visit their children in placement, including lack of transportation options, living a great distance from the facility, cost, limited visiting hours, restrictive visiting rules, or losing visitation rights because their child was being disciplined.”
- 55% of family members reported that it “was difficult or impossible to contact staff to ask how their child was doing or to receive information about their child’s progress or safety.”
- Only 32% of families reported “discussing release plans with juvenile justice system personnel prior to their child’s release.”
- 100% of parents of children incarcerated in adult facilities stated that children should be removed from adult jails and prisons. “Participants reported that inmates and prison guards victimized their children and parents lost all of their parental rights to affect decisions about their children once they entered the system.” Family members reported

⁴⁵ OJJDP Family Listening Sessions, July 2013, found on the web: <https://www.ojjdp.gov/pubs/241379.pdf>.

⁴⁶ *Id.*

⁴⁷ <https://www.ojjdp.gov/policyguidance/Youth-Family-Engagement/>.

concerns that adult prisons do not offer adequate health care or educational opportunities for children.

OJJDP also noted that families face many challenges to successful engagement with their children and participation in their child's treatment plan while incarcerated, such as a lack of institutional policies that are culturally or linguistically competent, visitation barriers, and difficulty obtaining information about their incarcerated child's status.

OJJDP guidance cites research supporting the need for family involvement to help incarcerated youth achieve better outcomes. The OJJDP-commissioned report by the National Research Council entitled "Reforming Juvenile Justice: A Developmental Approach," found that healthy adult relationships, either with a parent or another adult, are an important and "protective buffer" for children.⁴⁸

CASE STUDY - NATHAN⁴⁹

Nathan, an African-American teenager from one of Connecticut's urban communities, was 16 when he was incarcerated at MYI on multiple felony charges.⁵⁰ A review of Nathan's story shows time after time that when he needed or asked for help, he didn't get it or didn't get enough. Throughout his young life, Nathan's family was the subject of more than 16 reports to DCF alleging abuse and neglect of Nathan and other children in the family home.⁵¹ Nathan first became involved with Juvenile Probation when he was 8 years old and he was the subject of a Family with Service Needs Petition for "truancy." By age 10, Nathan was placed on juvenile probation after a charge for Breach of Peace for fighting.

By the time Nathan was 14 years old, he had been incarcerated in juvenile detention five times, with the 5th admission lasting for more than 100 days — 90 days more than the average length of confinement for youth detention. While in detention, Nathan presented with signs of Post-Traumatic Stress Disorder and he reported being afraid of his peers. Nathan is a special education student with multiple clinical diagnoses, including Borderline Intellectual Functioning, Conduct Disorder, ADHD, and enuresis (involuntary urination, especially by children at night). In juvenile detention, Nathan struggled with behavioral control, suicidal ideation, peer and staff relationships, and frequent refusal to engage in school. He was placed in room confinement or physically restrained on multiple occasions.

Detention management attempted a variety of interventions for Nathan, including advising staff about necessary precautions in addressing his behavior, instructing staff on how best to talk to Nathan, and learning

⁴⁸ National Research Council, Bonnie, R., Johnson, R., *et al*, "Reforming Juvenile Justice: A Developmental Approach," Committee on Assessing Juvenile Justice Reform, Committee on Law and Justice, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.

⁴⁹ Pseudonyms are used for all youth referenced in this Report.

⁵⁰ Robbery in the First Degree, Larceny in the Sixth Degree, Home Invasion and carrying a Dangerous Weapon (a BB gun).

⁵¹ Reports were made to DCF in 2002 (2); 2006; 2007; 2009; 2010 (3); 2011; 2012; 2013; 2014; 2016; 2017; 2018 (2). When Nathan was a baby, DCF substantiated neglect given concerns about how the children were being cared for in the home. When Nathan was 6, DCF received a report that the children's living conditions were poor and they were not attending school, but the allegations were unsubstantiated and the case closed because DCF could not locate the family. When he was 8, Nathan told an adult at school that his mother ties up his 6 year old sibling and puts tape over the 6 year old's and a baby sibling's mouth as punishment and to keep the baby from crying. The children's mother denied what Nathan was trying to tell adults at school, and authorities did not substantiate the case. Reports of suspected abuse and neglect continued for the next several years about Nathan and his siblings, including reports of physical abuse, substance abuse, lack of housing, medical and education neglect, all without sustained intervention and help for Nathan. There were significant untreated mental health issues with Nathan's family.

how to verbally prompt Nathan so he could understand facility expectations. Various safety measures were taken for Nathan, and he was placed on multiple mental health precautions due to his statements about wanting to harm himself, his repeated behavior of tying items around his neck, and his hoarding a sharp object to self-injure. After more than 3 months in detention, Nathan was discharged to the Connecticut Juvenile Training School (CJTS) – a secure juvenile correctional program for boys run by DCF. Nathan was adjudicated a Serious Juvenile Offender and committed as a delinquent to DCF custody.

The CJTS admission notes for Nathan documented his difficulties in detention, and that he had been placed on suicide watch several times for threatening to hurt himself or others. Nathan initially struggled at CJTS as well, and he experienced restraint and seclusion and sanctions on multiple occasions. Nathan did have a period of time at CJTS where clinical notes indicated that he began to settle in and engage more in counseling. However, he struggled again towards the end of his stay when there was no clear discharge plan.

After 11 months at CJTS, Nathan was discharged to his father's home. Nathan's father, like his mother, had previously been placed by DCF on the state's Central Registry of child abusers due to DCF's finding of a "pattern of substantiated [maltreatment]." While Nathan was incarcerated at CJTS, his father participated in only three family therapy sessions and he did not show up for the final two. During this time Nathan had a hard time at CJTS as his anxiety around discharge and his fears that he would not be successful in the community grew. Nathan heard through peer connections at CJTS that he might be targeted by peers in the community, and on several occasions he asked staff if he could remain incarcerated and not go home.

Nathan was ultimately discharged to his father's custody with DCF Parole Supervision and referrals for two community-based services.⁵² Nathan did not participate actively in either service. Nathan quickly struggled in the community, left his father's home, and lived briefly with other relatives. His records show he gravitated towards neighborhoods where he smoked marijuana, was at risk of escalating criminal behavior and of being targeted and harmed by peers and adults. He did not initially attend school upon discharge, due to what his record characterized as "issues with enrollment."

Within 3 months of discharge from CJTS, Nathan was arrested again and this time he was transferred to the adult prison system, incarcerated at the Department of Corrections' Manson Youth Institution (MYI). Since being incarcerated, Nathan has continued to struggle with behavioral control, suicidal ideation, and aggression, and he has experienced multiple sanctions, including physical isolation for days at a time.

Due to fights with peers and other violations of facility directives, Nathan has been placed multiple times in restrictive housing at MYI, on a sanction status called "Confined to Quarters (CTQ)," consisting of 23.5 hours per day of isolated cell confinement and no access to school or rehabilitative programming.⁵³ Nathan accumulated over 70 days in CTQ isolation over 9 months. Despite Nathan's history of substantial mental health issues and current needs, a review of his record over a two month period where he was placed in isolation on multiple occasions indicates that Nathan was primarily seen only for brief mental status checks and not for individual therapy sessions or other clinical programming. Nathan remains incarcerated; he is 17 years old.

One night while on CTQ Nathan was seen standing on the cell's bed with a sheet in his hand, threatening to kill himself. He was admitted to the facility infirmary where an assessment note documented his agitation,

⁵²Multidimensional Family Therapy-Re-entry/Family Treatment (MDFT-RAFT) and Fostering Responsibility, Education & Employment (FREE). The MDFT-RAFT program assists high-risk youth, ages 9-18, transitioning back to their communities following a period of incarceration or placement. The program includes targeted approaches for adolescents with a history of substance abuse and other behavioral issues. FREE programming includes an array of services to support the adolescent's growth in all areas of functioning: life skills and well-being, social, educational, vocational preparation, and employment.

⁵³A youth may receive and complete worksheets on his own while in CTQ, but youth are not provided educational services.

anxiety, and depression, but Nathan was ultimately deemed stable enough to return to isolation the following day. A cell-side mental status check the next day documented that Nathan expressed apathy about being isolated and about his own behavior. Mental health check-ins continued to be done with Nathan while he was in restrictive housing, but were always conducted at his “cell door.”

In meetings attended by OCA staff, it was clear that Nathan is poorly regarded by correctional staff, who view him as predatory and manipulative. Nathan has expressed willingness to connect with clinical professionals, but struggles with untreated mental health issues that prevent him from making those meaningful connections. Nathan has had limited programming while at MYI (OCA’s review found a poor programming utilization rate for many boys at the facility), and according to staff the lack of participation is due in large part to his disciplinary history,⁵⁴ highlighting a fundamental concern in correctional facilities, where youth with untreated mental health issues who exhibit angry or aggressive behaviors are afforded the least access to therapeutic interventions to help reduce those behaviors and allow the youth to better engage in rehabilitative programs while incarcerated.

Like many other boys at MYI, Nathan has not had any family visits while incarcerated. Yet without a positive relationship with a caring adult, intensive rehabilitative programming, staff support, pro-social opportunities and access to education, Nathan, and other boys like him, cannot and will not develop the tools they need to re-integrate successfully into the community.

Nathan’s trajectory is not representative of all youth served by the juvenile justice system, which successfully serves or diverts many children from incarceration to community and family-based programs. However, many children who move from juvenile detention into the adult prison system at a young age have stories like Nathan’s — lengthy histories of abuse/neglect, poverty, exposure to violence, fractured or inadequate education, several years of unmet and unrecognized needs, and ultimately escalating externalizing behaviors that place themselves and others at substantial risk. As Connecticut continues to reform its juvenile and adult criminal justice systems with an appropriate emphasis on prevention, diversion, and reduced reliance on incarceration of children with lower-risk profiles, it will be imperative to better serve children like Nathan, and ensure that the systems responsible for rehabilitating them have the philosophy, resources, and tools to provide the help he and others so desperately need.

COURT SUPPORT SERVICES DIVISION HARTFORD AND BRIDGEPORT DETENTION CENTERS

Connecticut juvenile courts have jurisdiction over children alleged to have committed crimes while under age 18. A child who is arrested for a delinquent act may be sent to and kept in one of the state’s two juvenile detention centers — secure holding facilities — per judicial order if the following statutory criteria are met: there is probable cause to believe the child committed the delinquent act; no less restrictive alternative is available; and a) the child poses a risk to public safety if released prior to the court hearing; b) there is a need to hold the child to ensure his or her appearance in court; or c) there is a need to hold the child for another jurisdiction.⁵⁵ A formal risk assessment is administered in detention to help determine the ongoing need to hold the child until a dispositional hearing is held. In addition, the child may not be held for more than seven (7) days without a detention review hearing to determine whether the grounds for detention are still met.⁵⁶

⁵⁴ Many youth at MYI are un-sentenced. Facility policies historically permitted un-sentenced youth to participate in programming.

⁵⁵ Conn. Gen. Stat. § 46b-133.

⁵⁶ Conn. Gen. Stat. § 46b-133(j) provides that: “In the case of any child held in detention, the order to detain such child shall be for a period that does not exceed seven days or until the dispositional hearing is held, whichever is shorter, unless,

Historically, detention facilities held children only while the child was awaiting trial, i.e. prior to adjudication for the delinquent act. If the child was adjudicated delinquent, the child could be committed to the custody of the Department of Children and Families (DCF) to be housed or confined in a DCF-licensed facility for 18 months (or possibly up to four years for serious juvenile offenses)⁵⁷ and provided with rehabilitation services.⁵⁸ Pursuant to Public Act 17-2, as of July 1, 2018, no child could be committed to DCF as a result of a delinquency adjudication. Jurisdiction to house and serve delinquent youth was transferred via the Public Act to CSSD. The scope and spectrum of support services for delinquent youth in the custody of CSSD was still being finalized during the development of this Report, but such services will include community-based and congregate care (group) programs (locked, staff-secure, and unlocked).

CSSD's secure detention programs are located in Bridgeport and Hartford. CSSD contracts with private providers for medical and mental health services. Bridgeport's bed capacity is 84. Hartford's bed capacity is 88. The average daily population for fiscal year 2016-2017 was **26** youth for Bridgeport and **22** for Hartford. The average length of stay in Hartford was **10.8** days (range of 0 – 61); the average length of stay in Bridgeport was **11.3** days (range 0-114).

- During the PUR (July 1, 2016 through June 30, 2017) there were **1384** detention admissions/**885** unique youth in the two state detention facilities, and the average length of confinement was between **10 and 11** days.
- For fiscal year 2017 the ages of youth admitted are as follows: **1** youth **10** years old and under; **12** youth between **11-12** years old; **82** youth **13** years old; **147** youth **14** years old; **317** youth **15** years old; **395** youth **16** years old; **401** youth **17** years old and **36** youth **18** years and older.

Unique Juveniles Admitted to Detention by Race and Ethnicity for FY 2017

Black	378
Black/African American	378
Hispanic/Latino	293
American Indian/Alaskan Native	1
Black/African American	67
Unknown	51
White	174
Other	2
American Indian/Alaskan Native	2
White	166
White	166
Grand Total	839

following a detention review hearing, such order is renewed for a period that does not exceed seven days or until the dispositional hearing is held, whichever is shorter.”

⁵⁷ State law designates numerous felonies as Serious Juvenile Offenses (“SJO”). Certain offenses may lead the juvenile to be transferred to the adult criminal court. Other offenses may still be adjudicated in the juvenile court. Historically, juveniles adjudicated as SJOs in juvenile court were subject to DCF commitment for up to four years.

⁵⁸ A child may also be placed by the Court on probation, subject to conditions of probation, or the Court may order other non-custodial dispositional options. Conn. Gen. Stat. § 46b-140(b).

- Discharge data – During the PUR there were **705** discharges home; **61** discharges to CJTS; **130** to DCF care; **99** discharges to community-based congregate care; **78** discharges to the DOC (**74** to MYI and **4** to YCI); **243** youth were transferred between CSSD facilities; **16** transfers to the Albert J. Solnit Psychiatric Center — a campus of in-patient and sub-acute beds operated by DCF.⁵⁹

A. SUICIDAL BEHAVIOR AND SUICIDE PREVENTION

CSSD provided the OCA with requested data as well as their policies, procedures, and audits for the PUR of July 1, 2016-June 30, 2017.

Bridgeport Detention Admissions: During the PUR there were **751** Detention Admissions. Of the **751** admissions, there were **491** unique individuals detained (**403** boys and **88** girls).

Hartford Detention Admissions: During the PUR there were **633** Detention Admissions. Of the **633** admissions, there were **394** unique individuals served (**320** boys and **74** girls).

CSSD provided the following information in response to OCA’s inquiry into incidences of suicidal behavior and self-harm during the PUR:

Mental Health Monitoring and Suicide Prevention in the Detention Facilities

The detention centers’ suicide prevention policy in effect for fiscal year 2016-2017 outlines three types of distinct monitoring stages:

1. **Mental Health Monitoring:** A stage used for a juvenile who presents with risk factors for suicide, but who is not considered actively or potentially suicidal.⁶⁰ During this stage, a staff member monitors the safety and well-being of the juvenile on a random staggered schedule of observation,⁶¹ in which observations are no more than 4 minutes⁶² apart when the juvenile is in his or her room and 15 minutes apart when the juvenile is outside the room. During the PUR there were **910** incidents of youth placed on Mental Health Monitoring. (See chart below for a breakdown of incidents/individual youth.)
2. **Suicide Watch:** A stage in CSSD’s monitoring of a juvenile who is potentially suicidal and/or presents with factors that result in increased risk for self-injurious or suicidal

⁵⁹ Transferred to Solnit on suspended detention order and “released” upon return to court.

⁶⁰ Type of behavior that lead to Mental Health Monitoring Status in Juvenile Detention: Juveniles with a history of psychiatric hospitalization, mental health treatment/diagnosis, and/or psychotropic medication; Juveniles with a history of a family member who has attempted/completed suicide; Juveniles with a history of significant trauma or loss; Juveniles with a history of one incident in which they engaged in self-injurious behavior, but only if the incident occurred more than 30 days ago and no medical care of psychiatric hospitalization resulted from the behavior; Juveniles who refuse to or are unable to participate during the intake process such that they fail to appropriately answer questions or complete screening instruments needed to assess their current level of safety; Juveniles with a history of homicidal ideation; Any other reason to cause staff concern not related to suicidal or self-injurious ideation or intent.

⁶¹ National Commission on Correctional Health Care standards emphasize the need for staggered, unpredictable monitoring of at-risk youth in confinement, writing that “precise 15 minute observation periods are not in compliance with NCCHC standards.” <https://www.ncchc.org/spotlight-on-the-standards-26-1>.

⁶² Four minute watches are recommended by juvenile correctional suicide prevention experts who explain that “brain damage from strangulation caused by a suicide attempt can occur within 4 minutes and death often within 5 to 6 minutes.” Hayes, L., *Guide to Developing and Revising Suicide Prevention Protocols within Jails and Prisons*, pg. 5, National Center on Institutions and Alternatives (2011).

behavior.⁶³ During this stage, a staff member monitors the safety and well-being of the juvenile on a random, staggered schedule of observation in which observations are no more than 4 minutes apart when [youth is] in their room and 15 minutes when outside the room. Unlike Mental Health Monitoring, on this heightened status, if the juvenile is placed in a room alone for disciplinary reasons unrelated to suicidal behavior, Constant Observation is required until the juvenile leaves the room or the disciplinary action has expired. During the PUR there were **668** incidents of youth placed on Suicide Watch Status in the detention facilities.

3. **Constant Observation:** A stage in the monitoring of an **actively suicidal** juvenile in which there is direct visual observation of a juvenile's safety and behavior on a continuous and uninterrupted basis.⁶⁴ This observation is conducted from within an arm's length of the juvenile. This observation must be performed without electronic devices, and a staff member must maintain a clear and unobstructed view of the juvenile at all times. There were **41** occurrences of Constant Observation of actively suicidal youth during the PUR in the detention facilities.

**Number of Monitoring Precautions
July 1, 2016 through June 30, 2017 by Detention Facility**

Facility		Mental Health Monitoring	Suicide Watch	Constant Observation
Bridgeport	Unique Juveniles	362 (307 M/55 F)	215 (146 M/69 F)	7 (2 M/ 5 F)
	Occurrences	536 (462 M/74 F)	339 (228 M/111F)	8 (3 M/ 5 F)
Hartford	Unique Juveniles	231 (183 M/ 48 F)	190 (121 M/69 F)	17 (7 M/ 10 F)
	Occurrences	374 (321 M/ 53 F)	329 (220 M/ 109 F)	33 (13 M/ 20 F)

	Suicidal Behaviors** ⁶⁵		All Precautions***	
Facility	Unique Juveniles	Percent*	Unique Juveniles	Percent*
Bridgeport	215 (155 M/ 60 F)	44%	473 (393 M/ 80 F)	96% (80% M)
Hartford	191 (140 M/ 51 F)	49%	366 (301 M/ 65 F)	93% (76% M)

⁶³ Type of behavior leading to Suicide Watch Status in Juvenile Detention: Juveniles who score at risk on the Suicidal Ideation Questionnaire; Juveniles who score Caution or Warning on the MAYSI-2 Suicide Ideation Scale; Parent, guardian, or other report of juvenile suicide risk; Juveniles with a history of suicide ideation or attempt; Juveniles who have engaged in self-injurious behavior in the past 30 days or report a history of two or more incidents of self-injury or one incident that resulted in the need for medical care or psychiatric hospitalization; Any statements made or observations noted during the intake process or to the transporting officer, indicating that the juvenile is a potential suicide risk; Any other reason causing staff concern related to potentially suicidal behavior.

⁶⁴ Type of behavior leading to Constant Observation Status in Juvenile Detention: Juveniles who are currently making verbal threats of suicide with or without a plan; Juveniles verbalizing current homicidal ideation; Juveniles who are actively engaging in self-injurious and/or suicidal behavior.

⁶⁵ *Percentage based on total unique juveniles served during time frame. A juvenile may be counted in more than one category during a detention stay.

**The "Suicidal Behaviors" includes juveniles on Suicide Watch or Constant Observation due to potential or active suicidal behaviors while in detention.

***The "All Precautions" includes all three of the precautions (Mental Health Monitoring, Suicide Watch, and Constant Observation) to provide the number of juveniles presenting with any risk for suicide.

Screening

CSSD reported a policy revision, effective September 1, 2017, which requires administration of the Columbia Suicide Severity Rating Scale (C-SSRS) to all youth admitted to detention, an evidence-supported tool that includes a series of questions used to prevent suicide. The C-SSRS is administered by multiple clinical and non-clinical staff at multiple checkpoints throughout the screening process. Prior to September 1, 2017, the Suicide Ideation Questionnaire (SIQ) was utilized.

Quality Assurance for Suicide Prevention

CSSD ensures that the medical/mental health provisions of the agency's suicide screening policy are monitored on a quarterly basis utilizing an audit tool agreed upon by CSSD and outside auditors. The audit tool examines actual occurrences of juveniles identified as a suicide risk or in need of enhanced monitoring and evaluates CSSD staff's adherence to agency policies related to monitoring and communication. CSSD also participates in an annual physical plant inspection. CSSD provided OCA with the results of the most recent audits conducted during the PUR which audit demonstrated that staff were substantially in compliance with agency practices. A Response to Suicide Prevention Plan is required within thirty days by each facility upon receipt of the physical plant Audit. The Plan is a response to the recommendations in the report as to how the facility will ensure the safety of juveniles. The physical plant inspection reports are reviewed by all levels of Juvenile Detention staff so they are aware of the inherent risks in the facility.

B. USE OF FORCE AND ISOLATION- RESTRAINT, SECLUSION AND RESTRICTIVE HOUSING

As previously discussed, there is a general prohibition on the use of solitary confinement (undefined) in detention facilities, and there is no state law addressing use of force or restraint. CSSD policy directives govern the use of room confinement, and physical and mechanical restraint in detention centers.

Physical Intervention (Emergency) is defined in CSSD policy as the application of approved techniques by a trained staff member to physically hold a juvenile who is out of control or harming themselves.

Chemical Restraint CSSD policy does not permit the use of chemical agents with juveniles.

Safe Crisis Management is defined as an approved physical intervention technique utilized by hazardous duty employees.

Mechanical Restraint is defined in CSSD policy as "any CSSD issued restraining device (metal or nylon handcuffs, belly chains, and/or leg irons)." Use of leg irons depends on whether the youth is deemed an escape risk. Use of belly chains is only permitted when the youth has a pending Class A felony charge.

Physical Isolation/Restricted to Room is defined in CSSD policy as "an intervention that involves the temporary placement of a juvenile in the juvenile's room as part of Progressive Facility Re-integration with the exception of school, meals, medical care, visits, phone calls, showers and one (1) hour of large muscle exercise daily." CSSD policies permit the use of room restriction as a disciplinary

response and as an emergency intervention for youth who become an “imminent threat to the safety and security of the facility.”

CSSD revised its Positive Behavior Motivation Program Policy in 2017 to shorten the maximum number of hours of room restriction allowed. The maximum restriction of 24 hours for significant behavior violations (assault, destruction of property) was shortened to of 12 hours. Minor violations now result in a maximum of 4 hours of room restriction.

Documentation. CSSD requires that an incident report be generated to explain the incident and progressive discipline must be attempted prior to the use of room restriction. There must also be documentation of a follow-up assessment of the youth, with three levels of administrative approval regarding proper use of room restriction, which includes supervisory review of the incident report and any videotape that may be relevant to the incident. Youth are permitted to come out of the room for school, meals, medical care, visits, showers, and exercise. Monthly meetings held by the facility superintendents incorporate review of a variety of performance measures, including the use of discipline and room restriction.

Reducing Reliance on Isolation. CSSD has reported recent work with the nationally-focused Center for Children’s Law and Policy (CCLP) on a *Stop Solitary for Kids* initiative, part of a campaign to end solitary confinement of youth in juvenile and adult facilities. The CCLP piloted a Room Confinement Assessment Tool (RCAT) at the Hartford and Bridgeport Detention Centers to assist in further decreasing reliance on room confinement in the facilities.

Training. CSSD staff are trained in the Safe Crisis Management⁶⁶ curriculum at the time of hiring and all staff must pass the SCM “skill-out” after pre-service training and annually thereafter.

**Number of Physical Interventions
for the 6 month period between January 1, 2017 and June 30, 2017 by Detention Facility**

Facility		Physical Interventions	Percentage of Juveniles who had a Physical Intervention
Bridgeport	Unique Juveniles	23 (21 M/ 2 F)	9%
	Occurrences	42 (40 M/ 2 F)	
Hartford	Unique Juveniles	27 (26 M/ 1 F)	14%
	Occurrences	37 (36 M/ 1 F)	

Mechanical Restraint of Minors. CSSD reported to OCA that “there were no mechanical restraints due to an ‘incident’ during the time frame,” but that “all juveniles are mechanically restrained during transport.”

⁶⁶ Safe Crisis Management is a curriculum designed to teach correctional facility staff members how to prevent and respond to crises. According to its website, “Safe Crisis Management® “SCM” is a comprehensive training program focused on preventing and managing crisis events, and improving safety in agencies and schools. Safe Crisis Management has a trauma-sensitive approach with emphasis on building positive relationships with individuals. Our program is designed to assist staff with responding to the needs of all individuals and particularly with the needs of the most challenging.” Training information found on the web at: <http://www.jkmtraining.com/>.

According to CSSD, detention staff recommends the type, if any, of mechanical restraints for purposes of going to court, and the judge accepts the recommendation or overrides it in accordance with the Use of Mechanical Restraints in the Juvenile Courtroom policy. Per CSSD, there were **57** occurrences of juveniles wearing mechanical restraints in court from January 1, 2017 to June 30, 2017. Per CSSD data, **ninety-six percent (96%)** of juveniles who appeared in court did not have any mechanical restraints.

PHYSICAL ISOLATION OF MINORS CONFINED IN CSSD FACILITIES (Restricted to Room data for the 6 month period between January 1, 2017 and June 30, 2017 by Detention Facility)

Facility		Restricted to Room	Percentage of juveniles Restricted to Room
Bridgeport	Unique Juveniles	39 (32 M/ 7 F)	15%
	Occurrences	93 (80 M/ 13 F)	
Hartford	Unique Juveniles	36 (35 M/ 1F)	19%
	Occurrences	75 (74 M/ 1 F)	

*Percentage is based on total unique juveniles served during the time frame.

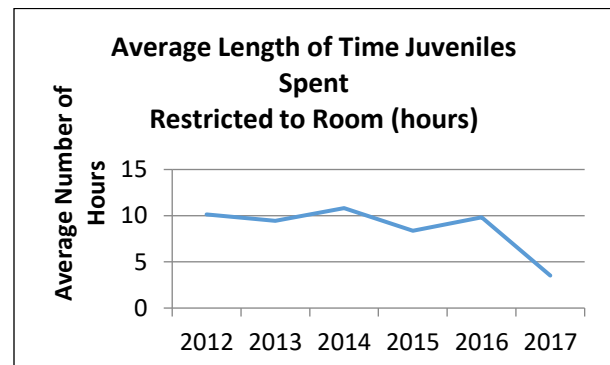
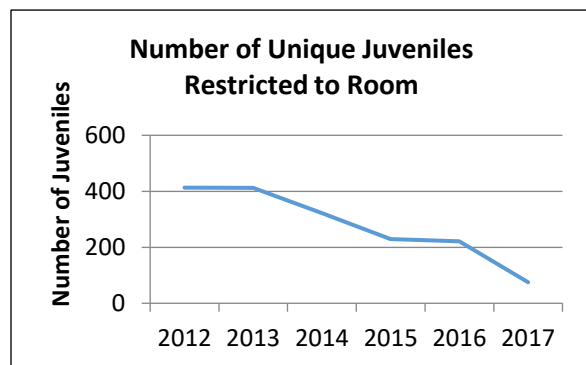
**Range of Hours of Restriction to Room
by Number of Occurrences and Detention Facility**

Room Restriction (Hours)	Bridgeport	Hartford
1-2	62 (51 M/ 11 F)	57 (55 M/2 F)
3-5	16 (16M/ 0 F)	15 (all M)
6+	15 (13 M/ 2)	3 (all M)

Bridgeport Detention: The average length of time Juveniles are restricted to room is **3.41 hours**.

Hartford Detention: The average length of time Juveniles are restricted to room is **2.40 hours**.

CSSD shared the following data that depicts a significant decline over the past 5 years in the number of juveniles placed on room restriction, as well as the length of time spent on room restriction further decreased since revisions to policy and procedure were made in January, 2017.



OCA Review of Selected Detained Youth Records

OCA examined the complete detention records of a small sample (6) of youth housed in detention facilities to review practices and documentation regarding room-confinement, restraint and

documentation regarding mental health service delivery. An additional sampling of records, (12) were reviewed during site visits for information regarding programming, treatment and access to education. The 6 youth records selected for complete review were those of youth known to OCA to have extensive behavioral health needs. OCA found that CSSD policies regarding documentation of incidents involving restraint and seclusion and required incident review were followed and documentation appeared complete.

OCA's record review revealed the potential for room confinement/physical isolation of juveniles who are designated as a **Security Risk** by the agency, or identified as needing to have an Individual Program Plan (IPP). According to CSSD policy:

Security Risk Group ("SRG"): A specifically designated group of juveniles possessing common characteristics, which serve to distinguish them from other juveniles or groups of juveniles, and which, as a discrete entity, pose a threat to the safety of staff, the Detention Center, other juveniles, or the community.

OCA learned that CSSD policy provides that a youth designated as SRG may be placed in a unit or appropriate location in the facility "in accordance with the juvenile's Individual Program Plan (see below)." The policy requires room searches three times per week, in-room checks every 15 minutes, and "living breathing flesh" must be observed during cell checks. Youth on SRG do not attend school but are provided packets of work while confined. Youth on SRG are not permitted to engage in activities with other youth and they are allowed large muscle "recreation" for one hour per day in a "controlled area."

An Individual Program Plan (IPP) is a "document developed by a CSSD multi-disciplinary team to address specific juvenile behaviors and re-integrate the juvenile into the detention population."⁶⁷ The IPP will include the number of restricted movement/confinement days, the location of the juvenile during the IPP, what programming/education the youth will have, and what the restorative justice plan will be. Progression with the IPP is "based on compliance." The youth will be permitted to rejoin the general population at the completion of the IPP.

OCA's youth-specific record review found that youth can have an IPP or be on IPP status without also being on designated SRG status. Both having an IPP and/or being designated SRG result in marked limitation of movement and access to programming. In follow-up of this discovery, OCA requested additional data from CSSD about the number of youth who had been placed on SRG status or who had an IPP during a recent 24-month period. CSSD reported that only one (1) youth had been placed on SRG during that time period and they were unable to provide data on youth assigned an IPP, as that information was not tracked in CMIS. OCA's review of the 6 records revealed an additional youth in CSSD custody during this period that had been designated SRG, leading to concerns regarding the documentation and reporting of SRG status.

OCA's case review highlighted the challenges that youth experience when in detention for prolonged periods. These youth are also more likely to be placed on different levels of mental health monitoring and restricted status.

⁶⁷ CSSD policy Section 8.307.

OCA could not determine how many youth were isolated or subjected to restricted environment/movement due to SRG designation or IPP status given the lack of available data regarding youth with IPPs.

OCA finds that while documentation in individual youth's detention records reflected adherence to agency policies regarding emergency interventions, OCA did not see substantial documentation regarding what interventions, therapeutic or behavioral, were implemented to assist youth who were more frequently restrained or confined to their rooms. A youth may have a special needs plan developed, but the records reviewed did not consistently reflect development of a clinical treatment plan, despite the fact that several of the youth had significantly longer stays in detention, more frequent admissions, and extensive mental

health treatment needs.

C. ACCESS TO MENTAL HEALTH TREATMENT

CSSD's health care continuum within the juvenile detention centers includes a contracted pharmacy, regionalized dental and oral surgeon services, a pediatrician, psychiatrist, psychiatric APRN, and licensed clinical social workers. The juvenile detention centers provide, through contract, the following services to detained youth:

- Licensed clinical assessment and evaluation;
- Crisis intervention and mental status assessment;
- Access to care/sick call request support;
- Evidence-based substance use intervention - MI/CBT;
- Psychiatric evaluation and psychotropic medication management;
- Emergency evaluation and Physician Emergency Certificate (PEC) authorization;
- Referral to higher level of care/inpatient services such as an emergency department or direct admission to Yale New Haven Hospital.

Data is collected on the aforementioned services through Performance Based Measures (PBM) reporting, an Electronic Medical Record, and clinical logs documented by mental health staff.

Screening and Evaluation in the Detention Centers

CSSD reported that all children are assessed at intake by a qualified mental health professional. During this mental health intake process, children are provided a DSM 5 diagnosis and a plan of care is developed where appropriate. The Plan of Care includes but is not limited to:

- Special Needs Plan which identifies mental health concerns and facility accommodations necessary to address the concerns;
- Referral to Psychiatric APRN or Psychiatrist for psychiatric consultation and medication management, if clinically indicated;
- Placement of child on appropriate mental health precaution status;
- Schedule of follow-up mental health sessions with children, which vary in accordance with clinical acuity (daily if placed on suicide watch or constant observation);
- Referral to higher level of care (Emergency Department or Direct Admission to Inpatient Unit) by mental health staff, if clinically indicated;
- Additional referrals to health care specialists outside of detention, as clinically appropriate;
- Daily interdisciplinary team meetings with facility staff, and weekly special needs meetings;
- Weekly psychiatric team meetings with mental health and medical staff.

CASE STUDY - - Tiffany

Tiffany is an example of a youth who experienced several admissions to detention and was subject to various levels of monitoring.

Tiffany was substantiated as a victim of child abuse and sexual assault. As a child committed to DCF, she experienced multiple disruptions in placement from foster homes, residential settings and inpatient settings. She was clinically assessed over the years to have reactive attachment disorder, complex trauma and persistent depression.

Tiffany was admitted to detention on 3 separate occasions in 2016 and 2017, the first 2016 admission she was detained for 34 days, the subsequent admission was for 3 days and her last admission was for 91 days. Tiffany's initial admission to detention in 2016 stemmed from an incident in a therapeutic residential program resulting in multiple charges (Assault 3rd Degree, Disorderly Conduct and Interfering with Officer/resisting). She was subsequently hospitalized at Solnit for over a year and was then returned to detention for 3 days from Solnit after being charged with assaulting a peer at the hospital. She returned to Solnit and was readmitted again to detention on charges related to assault on a hospital staff.

Review of Tiffany's detention records revealed that while detained, she was frequently very emotionally dysregulated, aggressive towards peers and staff, and experiencing suicidal ideation and self-injurious behaviors. Tiffany was subject to multiple physical restraints and frequent room confinement. Her unsafe behaviors resulted in multiple trips to the ED and ultimately the lengthy in-patient admission at Solnit.

Tiffany was placed on an Individual Program Plan ("IPP") on at least 3 separate occasions. During this time, she was restricted from participating in school and any therapeutic group activities for multiple days at a time. While on restriction, Tiffany did have regular check-ins with her counselor and mental health staff, but her detention support plan was not a comprehensive treatment plan designed to address her unmet needs and complex trauma history.

Mental health consultants are available on site in the detention centers Monday- Friday: 8:30am - 7:00 pm and Saturday and Sunday: 9:00 am -5:00 pm. Hours may vary if clinically indicated or if an

emergency arises. Remote consultation from a licensed qualified mental health professional is available 24/7.

Utilization of Mental Health Services by Detained Youth for the 6 month period between January 1, 2017 and June 30, 2017

As stated above, CSSD reports that every youth is seen by medical and mental health staff during his/her admission to detention. Some newly admitted youth may go directly to court in the morning before being seen. If they return, they are seen as soon as possible. There are some youth who are subsequently released in under 24 hours and may not be seen.

	Hartford PBM Data		Bridgeport PBM Data	
Type	January	April	January	April
Initial MHC ⁶⁸	34	45	34	49
Initial MD ⁶⁹	21	27	21	28
Follow Ups ⁷⁰	68	107	68	127
ED	0	0	0	0
Type	Feb	May	Feb	May
Initial MHC	32	36	38	51
Initial MD	26	24	19	24
Follow Ups	45	77	70	87
ED	0	0	0	0
Type	March	June	March	June
Initial MHC	33	33	64	51
Initial MD	27	39	34	16
Follow Ups	50	109	134	87
ED ⁷¹	1	0	0	0

⁶⁸ **Initial MHC** - This refers to all Mental Health Consultant Initial Intakes and Re-Admission Intakes completed on every juvenile entering a JRS/Detention Facility.

⁶⁹ **Initial MD** - This is defined as all Psychiatrist and Psychiatric APRN Initial Intakes and Re-Admission Intakes completed on every juvenile entering a JRS/Detention Facility.

⁷⁰ **Follow Ups** - This includes any mental health related follow up session or consultation provided by a Qualified Mental Health Provider (Mental Health Consultant, Psychiatrist, or Psychiatric APRN). Examples of follow up sessions are: precaution management, non-acute/routine, MI/CBT, sick call request, behavior motivation follow up, medication management, and post-precaution removal.

⁷¹ **ED** - This refers to a higher level of care referral to an Emergency Department or Hospital Unit via Direct Admission specifically for Mental Health Reason(s).

In response to OCA's inquiry of CSSD regarding youth referred from detention to the Emergency Department for mental health concerns, CSSD initially responded that 1 youth had been referred during the 6 month period (January 2017-June 30, 2017). Subsequent record review revealed several additional youth who were transported for acute mental health issues for the PUR (July 1, 2016-June 30, 2017).

CASE STUDY – EDGAR

Edgar age 17, was admitted for the 6th time to Hartford detention in August 2016. He remained in custody this particular admission until November 2016, significantly longer than the average length of confinement. Edgar's social history is significant for a lengthy history of abuse and neglect and exposure to domestic violence and sexual abuse in his home. He had previously been placed in foster care.

In 2016 he was living with his mother and siblings. Edgar is a special education student. Edgar's 2016 detention record indicates that he struggled during his confinement, frequently acting out toward staff and others. Detention staff were concerned about Edgar's mental health. They noted his "bizarre" behaviors and flat affect and observed that Edgar at times mumbled to himself and seemed paranoid. He often seemed agitated and minimally engaged with others. As his paranoia increased, he became more assaultive and unsafe toward staff and peers, although he spoke so softly he was often asked to repeat himself to be understood.

After several weeks in detention, there was a note in Edgar's record that a clinical consultation should take place with Solnit Psychiatric Center due to staffs' concerns about his presentation. Clinical notes suggest that this consultation did not take place as it was not approved by the court.

Pursuant to CSSD policy, Edgar should have been placed on a Special Needs Plan due to his paranoia and hypervigilance. However, the Special Needs Plan was not found in Edgar's detention record. During this admission, Edgar was restrained on several occasions due to assaultive behavior with peers and staff. On at least two occasions, he was placed on 48 hours of room confinement, during which time he was not permitted to participate in school (although his record indicates that he did some school work while on room confinement). The record indicates that mental health staff did brief check ins with him during this confinement. Edgar was also placed on SRG status due to his aggressive behaviors towards others. While on SRG status for multiple days, he was removed from the population and was not participating in school or programming.

Throughout his stay in detention, Edgar continued to struggle with engagement and peer conflicts. He was eventually discharged for his first and only admission to CJTS in November 2016 where he remained until April 2018. Shortly after discharge from CJTS, he was rearrested on additional juvenile delinquency charges. He is currently psychiatrically hospitalized for "competency restoration".

There are many youth like Edgar who are trapped in a cycle of delinquency and justice-involvement, in no small part due to a profound history of deprivation, child abuse and neglect, fractured service delivery, and resulting multi-focal treatment needs. Our system as a whole needs to improve its ability to 1) identify children like Edgar earlier and 2) assess and treat them within the context of community and family relationships.

As stated elsewhere in this report, CSSD detention facilities are intended as short-term custodial settings. A challenge for CSSD is how best to meet the needs of youth who present with complex mental health treatment needs while in custody and whose length of stay will likely significantly exceed the average stay of a youth in custody or who will likely return to detention multiple times.

OCA found it difficult to determine youth participation in rehabilitative programming through review of records. Clinical notes and youth meetings with counselors were documented in the Case Management Information System (CMIS). CSSD was unable to provide utilization data on rehabilitative programming within the detention centers. They reported that data on group programming is a new function that is being programmed into CMIS.

D. ACCESS TO EDUCATIONAL PROGRAMMING

CSSD reported that dedicated education space is provided in each detention center, and all juveniles are made available to participate in the education program in a timely manner. CSSD ensures that comprehensive education programs and related services are provided by qualified education agencies in compliance with federal and state requirements regarding assessments, curriculum, and attendance.

Consistent with C.G.S. § 10-253, the local education agency (LEA) for the location of a detention center has been responsible for the provision of education in the center. It should be noted that CREC was the education provider at Hartford Detention during FY 2016-2017. CREC notified Hartford Public Schools that it could no longer sustain a program at the facility for FY 2017-2018 given the low number of juveniles. Hartford Public Schools has contracted with DOMUS to provide education in the facility. DOMUS began providing education on September 5, 2017.

Bridgeport Public Schools has continued as the education provider at the Bridgeport Detention Center. CSSD reported to OCA that during this PUR (FY 2016-2017) that they communicated several program concerns to the Bridgeport Board of Education and Bridgeport Public Schools has instituted several program improvements for FY 2017-2018 (e.g., increased administrative oversight, oversight by a special education administrator, child-find procedures, weekly social worker, and an additional half-time teacher).

CSSD additionally reported that both detention facilities have implemented the Positive Behavior Intervention and Support (PBIS) framework through which academic and behavioral outcomes are improved by making positive behavior more desired and rewarding.

CSSD considers disciplinary issues to be school-related if they occur Monday through Friday, between the hours of 8:30 a.m. and 2:30 p.m., between September and May. “School-related discipline” only describes discipline wherein the youth is removed from school. Juvenile detention staff are responsible for the safety and security of the youth at all times. Detention staff are currently responsible for removing youth from school due to behavior problems. CSSD administration shared with OCA that they are currently reviewing the role of the Juvenile Detention Officer, as it relates to school and school-related discipline, to determine if the educational staff should instead be in charge of removing children from school for behavioral issues.

Any discipline that lasts 90 minutes or more is considered an out-of-school suspension as a matter of state law. Any child who is suspended is provided work to do in a space outside the classroom (either in a designated space on the education wing or on the child’s housing unit). CSSD provided:

Duration of Out of School Suspension by Occurrences and Unique Juveniles (September 1, 2016 – May 31, 2017)

Facility		1.5-3.33 Hours	3.35-5 Hours	5.01-8.33 Hours	8.35 Hours+	Total Juveniles
Bridgeport	Unique Juveniles	21	8	25	4	58
	Occurrences	31	9	36	5	81

Hartford	Unique Juveniles	14	6	5	3	28
	Occurrences	17	6	7	3	33

All juveniles attended school during the time period. Below is a chart that shows the percentage of juveniles suspended out of school compared to all juveniles.

Facility	Unique Juveniles with Out of School Suspension	% of Total Population
Bridgeport	58	12%
Hartford	28	7%

OCA review of attendance/discipline data from CREC/DOMUS, and Bridgeport Public Schools Bridgeport Public Schools (BPS) reported to OCA that “there were no instances of suspension, removal from school programming, or instances where youth were not permitted to attend school due to safety reasons.” BPS also provided OCA with a memo outlining procedures to be followed at the Detention Center regarding identification of youth who are eligible or potentially eligible for special education services. The memo outlines the details of BPS’ child-find procedures, including the referral and testing process, and notes that a PPT must be scheduled within 2 weeks.

Data from CSSD regarding attendance and discipline conflicted with data provided by BPS, although this discrepancy may be due to the fact that detention staff are responsible for monitoring youth behavior in school and conducting classroom removals when deemed necessary. However, it is important for BPS officials to document any school removal to ensure accurate attendance information. As stated above, CSSD indicated that it is re-evaluating this practice going forward.

For Hartford Detention, CREC reported to OCA that it had no attendance data and that any relevant attendance and discipline data would be discoverable from each individual student’s school district.⁷² CREC, like BPS, stated that it did not suspend students from school. The new provider, DOMUS, reported that from September 2017 (beyond the original PUR for OCA’s report), the total unduplicated number of students served was **211**. DOMUS also reported that it does not suspend students. Hartford’s corporation counsel reported to OCA that many students in the Hartford Detention Center are already identified as receiving special education services prior to arriving in detention and the students’ IEPs are requested from sending districts. When necessary, a referral for special education evaluation is made, although the attorney noted that the detention center typically does not have students long enough to complete the full referral process. Sending districts are therefore notified if the detention center has begun the referral process or if it is believed that a referral for special education evaluation is necessary based on screening protocol.

OCA Review of Youth –Specific Records

Detention records reviewed by the OCA revealed that youth exhibiting disruptive or dysregulated behaviors are initially removed from school by detention staff for shorter periods with a progressive increase in time removed from the classroom based on the youth’s continued presentation and behavior. OCA did find that youth who are sanctioned with “room confinement” are generally

⁷² Hartford’s corporation counsel reported to OCA that as CREC was no longer providing services to the detention center the city’s contract with the vendor which provided the electronic reporting system was terminated and all information was forwarded to the school districts as part of the students’ files.

permitted to attend a school so long as they are not engaged in unsafe behaviors, with some exceptions for certain youth on longer-term confinement (Edgar, for example, did not attend school when he was placed on 48 hours of room confinement). Detention records did not include educational information or educational case plans. OCA did not make a separate request for any full educational records for detained youth for the purpose of this review.

During the course of this review, CSSD administrators reported to OCA that “Every effort is made to have all juveniles safely attend the education program daily. Juveniles designated as a security risk and who display aggressive/unsafe behavior will be provided alternative educational programming by the education provider. This work can be completed on the housing unit or in another area of the facility deemed appropriate.”

As previously described, designation of SRG results in marked limitation on youth’s movement and access to group programming. OCA’s review of the records of the 2 youths found to be on SRG/IPP status revealed that they did not attend school while on restricted status, but that work packets were provided to the youth on the unit. One to one tutoring was not provided.⁷³

E. ABUSE/NEGLECT AND MANDATED REPORTING IN DETENTION CENTERS

All juvenile detention officers, supervisory, management official and professionals staff at detention facilities are mandated reporters.

CSSD initially reported to OCA that all agency contractors are required to report abuse or neglect, but upon further discussion CSSD administrators stated that the contracted Ombudsman was not expected to function as a mandated reporter, but noted that at “any time the Ombudsman can request that detention staff submit a [report of suspected abuse or neglect] to DCF.”

DCF records indicate that there were **12** reports of suspected abuse or neglect of minors confined in the Hartford and Bridgeport Juvenile Detention Centers between January 1, 2015 and December, 2017 that were accepted by DCF for investigation. DCF substantiated **1** of **12** of these reports as constituting abuse or neglect.

The **12** reports made between 2015 and 2017 contained various allegations of abuse or neglect including sexual abuse of girls detained in the facilities; physical abuse of children through inappropriate use of force, and physical neglect of children.

Reports were made to DCF by various individuals: mental health professionals, law enforcement, detention management, and detention/probation staff members. There were no reports of suspected child abuse/neglect to DCF from the CSSD-contracted youth ombudsman.

In 2017 there were **4** reports to DCF alleging wrongful sexual exploitation/abuse of incarcerated girls by detention employees. One of these reports was substantiated by DCF.

- February, 2017 Hartford Detention. Report made by DCF staff member regarding allegation of sexual abuse by unknown detention staff. The report was investigated by DCF and unsubstantiated.

⁷³ The lack of tutoring was confirmed by CSSD administrators in correspondence with the OCA.

- March, 2017 Bridgeport Detention. Report made by facility superintendent regarding suspected sexual exploitation of a girl by Juvenile Detention Officer. Multiple children were interviewed but all denied sexual exploitation or knowledge thereof. The allegations were not substantiated, but DCF identified concerns regarding the detention officer's misuse of CSSD computers for personal or other inappropriate purposes. The Judicial Branch terminated the employee.
- August, 2017 Hartford Detention. Report made by mental health professional alleging possible sexual abuse of female detainee by a Juvenile Detention Officer. Allegations were investigated by DCF and found unsubstantiated.
- August, 2017 Hartford Detention. Report made by law enforcement regarding alleged sexual abuse of an incarcerated girl by a detention officer. Allegations were substantiated and the perpetrator was criminally charged for sexual assault.

On November 16, 2017, the DCF Commissioner sent a letter and accompanying memorandum to the Chief Court Administrator of the Connecticut Judicial Branch, copied to the Office of the Child Advocate, outlining concerns about what the Commissioner characterized as a “prevailing culture”⁷⁴ in the detention centers “that has led to the widespread assumption by female residents that Detention Center staff are willing to have inappropriate contact with them,” and concern that the Judicial Branch facilities are “unsafe and unhealthy for many of the juvenile residents.” The accompanying memorandum included an outline of DCF’s “Program Concerns” identified by DCF during recent investigations, including the following:⁷⁵

1. The failure by CSSD to correct staff behavior adequately.
2. The failure by CSSD staff to report suspected child abuse or neglect timely.
3. The failure by CSSD staff to respond appropriately to an escaping juvenile.
4. A CSSD staff member’s permitting two children to access Facebook on the staff member’s personal phone.
5. A CSSD detention staff member’s inappropriately accessing the confidential records of children, including those who had left the facility.
6. The failure of staff to submit adequate documentation of certain incidents.
7. The failure of certain detention staff to exhibit appropriate boundaries with respect to children.

The Chief Court Administrator responded to the DCF Commissioner.⁷⁶ An informational public hearing was convened by the Connecticut General Assembly’s Children’s Committee on January 25, 2018, to discuss the substantiation of sexual abuse by a juvenile detention officer, the concerns outlined by the DCF Commissioner, and to hear from state agency officials, including the Office of the Child Advocate.

As part of OCA’s ongoing review, OCA reviewed the following sources of information:

⁷⁴ Letter from DCF Commissioner J. Katz to Hon. Patrick Carroll, Chief Court Administrator, Court Support Services Division, dated Nov. 16, 2017, on file with OCA.

⁷⁵ In 2015 and 2016 there were 6 DCF investigations into allegations of abuse and neglect in the detention facilities. There were no substantiations and 1 program concern documented during that time frame. The program concerns outlined above were identified and documented by DCF between September and November 2017.

⁷⁶ Letter from Hon. Patrick Carroll, Chief Court Administrator to DCF Commissioner J. Katz dated.... On file with OCA

- DCF’s memorandum of concerns.
- All records identified in DCF’s memo, as well as child-specific case records and video-taped footage of certain incidents involving children in the detention centers.
- Multiple reports from the CSSD-contracted Ombudsman and the multiple youth surveys about conditions of confinement in the detention centers.
- All documents from CSSD that pertained to corrective actions the agency has been taking to address concerns identified by DCF, and recommendations from the CSSD operational consultant, CSSD administration, and community stakeholders.
- OCA met with the CSSD consultant and reviewed the draft report and recommendations.⁷⁷ The consultant report regarding detention center operations was finalized in November 2017.
- OCA sought feedback from the Public Defender’s Office regarding any concerns juvenile public defenders may have regarding conditions of confinement or abuse and neglect of their clients in the detention centers.

In summary, the CSSD operations consultant found CSSD policies to be current, consistent with national best practices, and regularly reviewed and revised. He further found that certain concerns identified by DCF or CSSD were the result of “staff misconduct” and not “policy deficits.” His report focused on changes that could be made to ensure staff compliance with agency expectations through improved supervision protocols, increased managerial and administrative oversight, and additional staff training. Recommendations included:

1. Strengthening supervisory and managerial capacity and responsibilities through re-alignment of job responsibilities and elimination of certain job classifications;
2. Increasing staffing, including hiring more female Juvenile Detention Officers and ensuring qualified women are well represented in the ranks of supervisors and administrators;
3. Increasing responsibilities for facility administration regarding inspection of milieu and compliance of staff with agency policies;
4. Improving certain aspects of the physical environment of the Bridgeport Detention Center;
5. Considering changes to the behavior management protocols by “reimagining” the policies to better reflect needs of older children, who are more likely to be detained today than ten years ago.
6. Ensuring regular training of detention center staff on ethical rules and the importance of establishing clear boundaries between incarcerated children and detention staff.

OCA notes that CSSD took several steps to respond to concerns of staff misconduct in 2017, including bringing in an operations expert to conduct a comprehensive review of facility operations, contracting with outside experts to address gender-specific reforms, and

⁷⁷ CSSD contracted with Leo Arnone (former Commissioner of the Department of Correction, DCF Juvenile Justice Administrator and CSSD Administrator) in August 2017 to review detention center operations and make recommendations to Judicial Branch leadership regarding any necessary changes and reforms.

OCA's review of the CSSD-contracted Ombudsman reports and youth surveys, which are not administered in the presence of detention staff, revealed generally favorable responses to safety and security questions. The most negative responses from youth were about their lack of contact with

An August, 2018, report in the Hartford Courant outlined staff concerns regarding injuries in the Bridgeport detention facility, reportedly a symptom of understaffing and increased reliance on the detention facilities in the wake of the CJTS closure and pending development of community-based secure/staff-secure programs. The Judicial Branch responded to the concerns by outlining its efforts to bring in additional staff and decrease use of overtime, and continue its work to ensure an adequate continuum of treatment facilities and services for justice-involved youth transferred to the Branch's jurisdiction. No statistical information was published regarding the trend line in youth/staff injuries or the nature of the injuries incurred.

probation officers while in detention, and in some cases about lack of access to outside exercise, as well as concerns about difficulty sleeping.

OCA's information request from the Public Defender's Office likewise did not reveal systemic concerns regarding abuse or neglect of clients in the detention facilities. OCA's

discussion with child/juvenile-justice advocates did raise issues regarding the adequacy of programming, particularly second-shift and weekend programming for detained children.

Federal Prison Rape Elimination Act (PREA)⁷⁸ audits conducted by a certified DOJ auditor in November, 2017, were completed with no corrective action recommended for the detention centers.

CSSD reported to OCA that it has taken or is in the midst of taking the following steps:

1. Increasing the number of required facility tours to be conducted by the center superintendent, deputy superintendent and shift supervisors.
2. Re-aligning facility supervision responsibilities through creation of a management level position to oversee each working shift in the detention centers.
3. Adding central office staff (August 2018) to assist with oversight of operations in the detention centers.
4. Adding approximately 100 juvenile detention center staff between Spring 2018 and December 2018 (involving a combination of recalled staff, new hires and per diem staff).
5. Updating "Ethics and Boundaries" training and including such training as part of the 2018 forty-hour, in-service training week for all juvenile detention staff and 4 hours of such training to be required annually.

Requesting gender-responsive consultation from the Council on Juvenile Correctional Administrators and the Center for Juvenile Justice Reform at Georgetown University as part of CSSD's Youth in Custody Practice Model. After receiving expert recommendations to improve outcomes for girls, including a recommendation to remove female youth from the detention centers, CSSD submitted an application to the Vera Institute for their Initiative to End Girls' Incarceration, and is working on entering into a Memorandum of Agreement for technical assistance around participation in Vera's learning network. CSSD also convened a girls' stakeholder group, which met in May 2018, and will meet again in October 2018.

⁷⁸ PREA was passed in 2003 to "provide for the analysis of the incidence and effects of prison rape in Federal, State, and local institutions and to provide information, resources, recommendations and funding to protect individuals from prison rape." National PREA Resource Center (<https://www.prearesourcecenter.org/about/prison-rape-elimination-act-prea>), citing Prison Rape Elimination Act, 2003.

F. ACCESS TO FAMILY CONTACT/FAMILY ENGAGEMENT

OCA received the following information from CSSD regarding family visits (January 1, 2017-June 30, 2017):

Number of Family Visits between January 1, 2017 - June 30, 2017 by Detention Facility

Facility		Number of Family Visits	Percentage of Juveniles with Family Visits
Bridgeport	Unique Juveniles	90	36%
	Occurrences	273	
Hartford	Unique Juveniles	72	38%
	Occurrences	259	

Frequency of Family Visits by Number of Juveniles and Detention Facility

Frequency of Visits	Bridgeport	Hartford
1-5	73	60
6-10	16	8
11-15	1	2
16+	0	2

Availability of Family Therapy in Detention

CSSD responded that the Juvenile Detention Centers are short-term, pre-adjudicatory facilities and do not offer family therapy. A Classification and Program Officer (CPO) is the child's case manager while in detention. The CPO's role is to ensure a continuity of care, provide discharge planning, communicate with the child's Probation Officer, and engage with the family through weekly family contact in accordance with procedures outlined in the Discharge Planning Policy.

OCA FINDINGS: CSSD DETENTION FACILITIES

SUICIDAL BEHAVIOR AND SUICIDE PREVENTION:

1. CSSD policy and practice recognizes the potential risk of self-harm for all youth admitted to detention.
2. During the PUR, CSSD reported 688 incidents of youth placed on suicide watch status, and 41 occurrences where constant observation was needed to support actively suicidal youth.
3. OCA's record review revealed multiple occurrences of youth being placed on Constant Observation, on different occasions throughout their stay in Detention, for self-injury, suicidal ideation and restricted statuses.

USE OF FORCE AND ISOLATION-RESTRAINT, SECLUSION AND RESTRICTIVE HOUSING:

4. CSSD facilities reported that, on average, 11.5 percent of incarcerated youth were physically restrained during the PUR. CSSD protocols direct the mechanical restraint of **all** youth during transport.
5. While CSSD policy directs sparing use of cell/room confinement, in the small sample record review done by OCA, several examples of physical isolation for behavior management were found.
6. OCA's review of a sampling of youth-specific records revealed instances where CSSD utilized detention's most restrictive levels where youth can be isolated from the population for multiple days at a time, with no access to group programming or school.
7. CSSD was unable to provide data regarding how many youth were placed on restricted status during the PUR.

ACCESS TO MENTAL HEALTH TREATMENT:

8. OCA's review of youth-specific records found that CSSD is challenged in meeting the treatment/support requirements for youth who present with profound mental health treatment needs while in custody and whose length of stay significantly exceeds the average stay of a youth in pre-trial custody.
9. CSSD was not able to provide OCA with utilization data regarding rehabilitative/group programming. The absence of this data made it difficult to determine what type of pro-social and rehabilitative programming is occurring outside of school time. CSSD has since added this to their data management system and has shared that it should be able to report on this in the future.
10. Record review did show that youth receive check-ins from clinical staff while placed on either a restricted status or some level of mental health monitoring, however, regular individualized therapy is not a component of ongoing service delivery.

ACCESS TO EDUCATIONAL PROGRAMMING:

11. Connecticut law provides that education in the detention centers is the responsibility of the local school district. Bridgeport Public Schools provides educational services to the Bridgeport detention center, and Hartford Public Schools contracts with a community-based provider to deliver education services in the Hartford detention center.
12. OCA examined attendance and discipline information from CSSD and the two responsible local school districts and found that neither school district was able to provide reliable data regarding incarcerated youth's attendance and instances of school removal. CSSD, however, did keep data on school removals, which showed that just under 10 % of confined youth were subject to a school suspension while in detention.

13. OCA's record review identified youth who were placed on restricted status who were not allowed to attend school programming. CSSD reported that youth may be provided school work to complete on the unit, but individualized instruction was not provided.

ABUSE/NEGLECT AND MANDATED REPORTING

14. Over a 36 month period, there were 12 reports to DCF of suspected abuse or neglect of children in juvenile detention facilities. DCF substantiated 1 of these reports and made a finding of sexual abuse. Over a 3 month period in late 2017, DCF identified numerous program concerns that it concluded contributed to unsafe conditions for youth in detention, including staff failure to follow agency policies, and staff failure to timely report suspected abuse or neglect of children⁷⁹
15. The Judicial Branch invited consultant Leo Arnone, a former executive administrator for DOC, DCF, and CSSD, to conduct a review of agency policies and conditions in the detention centers. Mr. Arnone's report, published in November 2017, concluded that agency policies are progressive and comprehensive, but he recommended action steps to improve quality assurance in the facilities and ensure facility and staff compliance with agency expectations. The Judicial Branch adopted Mr. Arnone's recommendations and has committed to a series of quality improvement activities, including an increase in staffing, shifting of managerial assignment/responsibilities, enhanced staff training, and consultation with national experts on juvenile justice reform and gender-responsive programming.
16. The CSSD ombudsman has been an agency contractor and has not functioned as a mandated reporter. The ombudsman did not make any reports of suspected abuse or neglect to DCF during the 36 month period reviewed by OCA. CSSD informed OCA that it would seek to amend the ombudsman contract to require that ombudsperson/s will be required to report suspected child abuse/neglect to the Department of Children and Families Careline going forward.

ACCESS TO FAMILY CONTACT/FAMILY ENGAGEMENT

17. CSSD provides visitation hours on evening weekdays and during the day and evening on weekends, with opportunities for additional accommodations as needed. The detention centers offer twice monthly family events to encourage engagement. Data shows that just over 1/3 of children in detention received a family visit while incarcerated. Detention does

⁷⁹ During this time frame, the Connecticut General Assembly passed a new budget law transferring DCF's juvenile justice responsibilities to CSSD.

not offer family therapy due to the historically short-term, pre-adjudicatory nature of the facilities.

18. OCA record review revealed that detention staff appropriately made attempts to contact youths' guardians throughout their stay to address various issues in detention.

AGENCY RESPONSE: CSSD

In response to OCA findings related to access to mental health screening and treatment, CSSD leadership reported confidence in its screening and short-term assessment policies and practices, emphasizing that pretrial detention, typically short-term, has significant limitations regarding mental health treatment and has not been considered a treatment environment. In response to the recent shift in statutory responsibilities for adjudicated youth, CSSD is currently engaged in efforts to modify its policies and programming to effectively meet the needs of a significantly more complex population of youth who will experience longer detainment. CSSD has added staffing to its detention centers and enhanced training and supervision to meet the needs of youth in their care. In addition, CSSD has developed several family engagement videos that are posted on its websites and available to be shown to parents during visitation. CSSD has also indicated that it expects data reporting discrepancies to be reduced with modifications to its data management system in 2019

CONNECTICUT DEPARTMENT OF CORRECTION *MANSON YOUTH INSTITUTION FOR BOYS *YORK CORRECTIONAL INSTITUTION FOR GIRLS

Youth who are charged with commission of Class A felonies, such as murder, sexual assault, kidnapping, arson, home invasion, and certain Class B felonies such as assault in the 1st degree and burglary in the 1st degree, are automatically transferred to the adult criminal court, so long as the offense was allegedly committed after the youth turned fifteen.⁸⁰ Some B felonies, all C, D and unclassified felonies are subject to discretionary transfer rules that allow prosecutors to file a transfer motion if there is probable cause to believe the crime charged actually occurred and the best interests of the child and the public will not be served by keeping the case in the juvenile court.⁸¹

121 youth were transferred to the adult criminal court in fiscal year 2017.⁸² Youth who are transferred to the adult criminal court may be incarcerated at a facility run by the DOC both before trial and after conviction.

A Department of Justice Office of Juvenile Justice and Delinquency Prevention ("OJJDP") and the National Institute of Correction ("NIC") technical assistance guide (hereinafter "the OJJDP/NIC Guide") discusses the significant risks youth face when incarcerated in adult prisons, including "much higher risks of sexual and physical assault, suicide, and mental health problems."⁸³ Specifically, the author/s express concern that youth in adult prison are more likely to be assaulted, more likely to

⁸⁰ Conn. Gen. Stat. § 46b-127.

⁸¹ *Id.*

⁸² Court Operations, Judicial Branch.

⁸³ OJJDP/NIC Guide, *supra* N. 2, Deitch, M. "Historical Perspective," Chapter 1, pg. 16.

commit suicide, and less likely to have access to programming, services, and family support than youth in the juvenile system.⁸⁴ The OJJDP/NIC Guide author/s cautions that generally speaking, across the country, there are “no monitoring systems for ensuring safe and healthy conditions of confinement for youth being held in adult facilities.”⁸⁵

All individuals admitted to the DOC undergo mental health screening and are assigned a mental health score, which determines mental health services during the period of incarceration. During the PUR of July 1, 2016 - June 30, 2017, all inmate medical and mental health services were provided by UConn Correctional Managed Health Care.⁸⁶

Manson Youth Institution

The Manson Youth Institution (“MYI”) is a level 4 high-security facility which houses male offenders ranging in age from 15 to 21 in ten separate buildings. Pursuant to federal law requirements which mandate juvenile offenders be housed separately from adult offenders (age 18 and up), MYI houses juveniles in two separate housing units, I and J. These two units are separate from the rest of the compound which houses, in total, over **500** youthful and young adult offenders. The DOC describes MYI as a “high security, adult correctional institution. MYI is a celled facility. The use of cells to confine offenders is a long-standing practice in high security, adult correctional institutions, as is the use of mechanical restraints, chemical agent and gang management strategies.” What is noticeably absent from that description is that youth are housed in antiquated cells that fail to meet current accreditation standards and are equipped with a bed, small sink, and stainless steel toilet bowl.

There are approximately **55** youth under age 18 incarcerated at MYI at any given time over the last year. Fifteen year olds (referred to as Juvenile Offenders) must be separated from 16 and 17 year olds (referred to as Youthful Offenders) for the purpose of sleeping. About half of all incarcerated youth are awaiting trial.

Youth attend school with the rest of the population and may have contact with young adults in other supervised settings, but not in the housing units. MYI does not have a facility-wide cafeteria or dining hall, so all meals are served in the housing units.

Because certain minors confined at MYI are also in the custody of DCF, there is an interagency liaison (a DCF employee) who maintains an office at the prison. It is the role of the DCF liaison to assist with planning for DCF-committed youth.

Upon commencing this review, OCA’s information requests were made to the DOC Commissioner’s office and copied to facility wardens. DOC central office deferred to the facility wardens for facility specific data, including education, and policy/practice information, and to CMHC facility administration for information regarding mental health services.

⁸⁴ OJJDP/NIC Guide, *supra*, N. 2, Clark, P., Ch. 2 “Types of Facilities,” pg. 6, citing a study by Malcolm Young and Jenni Gainesborough for the Sentencing Project, entitled, *Prosecuting Juveniles in Adult Court: An Assessment of Trends and Consequences*, (Washington, DC: The Sentencing Project, 2000).

⁸⁵ *Id.*, pg. 7.

⁸⁶ UConn Health assumed responsibility for all global medical, mental health, pharmacy, and dental service provision from the Connecticut Department of Correction in November 1997. As of July 1, 2018, Correctional Managed Health Care, a division of UConn Health, has been dissolved. UConn Health still provides care to inmates who come to their campus but no longer provides care in the prisons. Source <https://health.uconn.edu/correctional>.

Facility administration reported that **104** youth were admitted to MYI during the PUR July 1, 2016-June 30, 2017:

- **14-** 15 year olds
- **40** -16 year olds
- **50-** 17 year olds.

A point in time examination of 53 youth incarcerated at MYI during the PUR revealed:

- **6** White youth
- **6** Hispanic youth
- **41** African American/Black youth

33 Youth were discharged from MYI between January 1 and June 30, 2017 to the following communities:

(7 Hartford) (5 Bridgeport) (4 Naugatuck) (3 New Haven) (2 Meriden) (2 Danbury) (2 New York) (2 Hamden) and 1 each to: (West Hartford) (Brookfield) (Monroe) (West Haven) (Trumbull) (Stamford) and (Vernon).

10 youth were readmitted to MYI during this same time.

York Correctional Institution

The York Correctional Institution (“YCI”) is a high-security facility and serves as the state's only correctional institution for female offenders of any age. It serves all superior courts in Connecticut and manages all pretrial and sentenced female offenders, whatever the security level. The population of female juvenile/youthful offenders has decreased significantly over the years. Female youth, like their male counterparts at MYI, are housed separately from the adult population.

6 female youth offenders were admitted to YCI during the PUR:

- **2** African American/Black youth
- **4** Hispanic youth

2 youth discharged from YCI during the PUR: One youth discharged before trial to her mother’s home and the other youth released, per YCI, “is listed as homeless.”

A. SUICIDAL BEHAVIOR AND SUICIDE PREVENTION

Research shows that youth who are deeper in the justice system have higher prevalence rates of suicidal ideation and behavior. “Youth sampled during stays in post-disposition secure facilities appear to have the highest prevalence rates of suicidal ideation and attempts.” Girls have higher prevalence rates than boys.

Teplin, L., Stokes, M., et al., *Suicidal Ideation and Behavior in Youth in the Juvenile Justice System: A Review of the Literature*, Jour. Correct. Health Care (July 2015).

Screening at the DOC

DOC Suicide Prevention Policy provides that the facility “shall actively identify and monitor inmates who may be at risk of self-harm. Each facility shall establish procedures for suicide prevention and intervention.” Policy also provides that each direct contact employee shall receive training in suicide prevention and related topics. Newly hired staff with direct inmate contact shall complete one (1) full day of suicide prevention training prior to being assigned to a facility. Agency policies were developed in consultation with UConn Correctional Managed Health Care (CMHC).

DOC/CMHC policy requires all youth admissions to MYI and YCI will be screened utilizing the Massachusetts Youth Screening Instrument (MAYSI-2),⁸⁷ and the HR517 (Suicide Risk Assessment). Youth may be placed on “Mental Health Observation Status” if they are determined to be potentially suicidal, and such youth are to be “safely monitored.”

Suicidal Behavior at YCI

Administrators from YCI reported that there were **2** incidents of youth engaging in self-harming behavior at York.

Youth No. 1: Superficial cutting along with passive suicidal ideation, approximately 1x/month or less, beginning in November 2016. Youth #1 was assessed by mental health weekly and required one short term in-patient admission to the facility’s Mental Health Unit.

Youth No. 2: 1 instance of suicidal ideation without intent or self-injury, and one short-term in-patient admission to the facility’s Mental Health Unit.

Suicidal Behavior at MYI

MYI reported that there were **0** incidents of suicidal or self-harming behaviors by youth⁸⁸ incarcerated during the PUR.

DOC MYI facility administration reported **104** youth admissions during the PUR and, further, “all juveniles are priority intakes.” OCA was directed to CMHC with questions related to mental health assessment and intervention. Mental health specific data was provided by the MYI CMHC Supervising Psychologist.

CMHC reported **66** new youth intakes, **87** youth suicide risk assessments, **45** mental health infirmary contacts and **23** mental health infirmary admissions during the PUR. It is notable that there were many fewer mental health screens and suicide risk assessments than reported youth admissions during the PUR. **16/23** youth admitted to the infirmary were admitted upon admission to the facility. Infirmary admissions length of stay ranged 1-26 days for close observation for the following reasons:

- First time incarceration with a high bond;
- Feeling hopeless;
- Poor institutional adjustment;
- Skipping meals;
- Increased paranoia;
- Readmission to facility;
- Threatening self-harm;
- Multiple undisclosed suicide attempts reported as accidents in the Emergency Room.

⁸⁷ The MAYSI-2 is a brief behavioral health screening tool designed especially for juvenile justice programs and facilities. It identifies youths 12 through 17 years old who may have important, pressing behavioral health needs. It is a self-report inventory of 52 questions. Information about the MAYSI can be found on the web at: <http://www.nysap.us/MAYSI2.html>.

⁸⁸ In correspondence and discussion with DOC facility administrators and staff from UConn Correctional Managed Health Care, OCA sought information regarding both suicidal ideation/behavior and “any acts of self-injury,” whether of a suicidal or non-suicidal nature.

CMHC reported to OCA that there were **0** suicidal behaviors and **0** self-injurious behaviors during the PUR. CMHC defined “[s]elf-harming behavior is non-suicidal self-injury in which the individual has intentionally inflicted damage to the surface of his or her body that it likely to induce bleeding, bruising or pain (e.g., cutting, burning, hitting, rubbing), with the expectation that the injury will lead to only minor or moderate physical harm. (i.e. there is no suicidal intent).”⁸⁹

CMHC reported that a request for a “crisis contact” can come from a variety of sources and is triaged for emergency of need, risk assessment, and prevention of adverse incident. CMHC was unable to provide the relevant policies associated with these crisis contact procedures, reporting “[a]ll former UConn Health Correctional Managed Health Care Policy and procedures are under review post agency merger.”⁹⁰ OCA was informed that during the PUR, **5** Crisis Contacts were made, however CMHC was unable to provide any additional information regarding the nature or outcomes of the crisis contacts.

CMHC reported to OCA throughout the course of this review that certain data was challenging to retrieve (records prior to 2017 were not stored at the facility).⁹¹

All youth whose records were examined by OCA presented with multiple mental health risk factors for suicide or self-harming behavior, including histories of mental health diagnoses and significant treatment needs, poor adjustment to the facility, histories of abuse or neglect, and poor coping and adaptive skills.

Quality Assurance for Suicide Prevention and Response at MYI

DOC facility administrators provided agency policies regarding suicide prevention. Administrators did not provide information regarding quality assurance measures used to evaluate the efficacy of these suicide prevention policies, the safety of the physical plant, or the adherence of staff to suicide prevention protocols and communication requirements.

B. USE OF FORCE AND ISOLATION – RESTRAINT, SECLUSION AND RESTRICTIVE HOUSING

There are no standard definitions of restraint or seclusion contained in Connecticut law that apply to youth served by all agencies. For example, the state law that prohibits use of prone/face-down restraint of students due to concerns over airway restriction and chest compression is not applicable to incarcerated youth. Both prone and chemical restraint are utilized with youth in DOC custody.

⁸⁹ E-mail correspondence with MYI psychologist, on file with OCA.

⁹⁰ Email correspondence with MYI psychologist, on file with OCA.

⁹¹ Id.

New State Law Prohibition on Administrative Segregation

Conn. Gen. Stat. § 18-96b, *entitled Restricted Housing Status for Inmates. Employee Training and Wellness*, prohibits the use of “administrative segregation” for incarcerated youth in the custody of the DOC. The statute defines “administrative segregation status” as the “practice of placing an inmate on restrictive housing status following a determination that such inmate can no longer be safely managed within the general inmate population of the correctional facility.” This new law constitutes the only state statutory prohibition on the use of physical isolation of minors in the DOC. There are no state statutes governing the use of force on minors in the DOC, and the use of planned or unplanned force is governed solely by DOC directives.

Youth Incarcerated in the Custody of DOC

DOC initially reported 0 incidents of restraint or seclusion for the PUR. OCA subsequently submitted a request for data regarding DOC use of force (physical, mechanical and chemical) and the frequency and nature of disciplinary measures such as restrictive housing, both brief and longer term, as a disciplinary sanction or security measure.⁹² OCA also requested information regarding how the use of restrictive housing affects a youth’s access to educational, clinical, and rehabilitative programming.⁹³ As noted above, the state statute regarding restraint or seclusion of a “person at risk,” specifically exempts the DOC from exclusions on use of restraint and seclusion, although Public Act 16-186 requires the DOC to report to the legislature the *number* of restraints and seclusions using the definitions contained in the “person at risk” statute.⁹⁴ The DOC’s practices regarding the use of

⁹² OCA requested more recent information regarding 1) youth placed on “Restrictive Housing Status since January 1, 2018, and the length of each restriction; 2) educational logs for each youth including hours of daily educational instruction and location of instruction; 3) disciplinary reports for each youth since admission to MYI; 4) Mental Health assessments and evaluations at the time of youths’ placement into Restrictive Housing and any assessment/evaluation while in Restrictive Housing, including Mental Health scores; and 5) Documentation of regular clinical treatment for youth in Restrictive Housing.

⁹³ Specifically, OCA supplemented its original data request by asking the DOC for the following information—

1. The number and names of youth placed on Security Risk Group (SRG) status both during the PUR and again between 1/1/2018 and the present??
2. The number and names of youth and number of incidents of youth being placed on Extended Confined to Quarters Status (CTQ) from 1/1/2018 through 6/1/2018.
3. Documentation related to the provision of mental health screens, evaluations and treatment for youth prior to, during and after placement on restricted housing status (either CTQ or SRG).
4. Documentation regarding the provision of educational services to youth on restricted housing status, including attendance records, work samples, logs of service hours provided, and youths’ Individual Education Plans (IEPs) where applicable.
5. Documentation regarding access to visits, phone calls, rehabilitative services, and recreation time for youth on SRG and Extended CTQ status.
6. Documentation regarding creation and utilization of Behavior Plans for youth on Extended CTQ or SRG status.
7. Policies and protocols regarding the designation of youth for restricted housing status.

⁹⁴ Public Act 16-186 requires that beginning October 1, 2017 and annual thereafter, the DOC “shall compile records regarding the frequency and use of physical restraint and seclusion, as defined in [the person at risk statute] on children and youth twenty years of age or younger who are in the custody of the commissioner at the John R. Manson Youth Institution, Cheshire, and shall submit a report summarizing such records ... to the joint standing committee of the General Assembly having cognizance of matters relating to children. Such report shall address the prior year and shall indicate, at a minimum, the frequency that (1) physical restraint was used as (A) an emergency intervention, and (B) a nonemergency intervention, and (2) restricted housing or other types of administration segregation or seclusion were used at such facility.” Full text of Public Act 16-186 can be found on the web at <https://www.cga.ct.gov/2016/ACT/PA/2016PA-00186-R00SB-00075-PA.htm>.

isolation within the facility are controlled, in part, by the recent state law prohibiting the use of administrative segregation for incarcerated youth.

Restraint or staff use of force is governed by DOC Directives. DOC responses to OCA requests for information stated that all staff are trained in use of force protocols. Copies or reference to specific curricula were not provided.⁹⁵

Mechanical Restraint -- DOC Directives define restraint as “any mechanical device used to control the movement of an inmate’s body and/or limbs, including but not limited to flex cuffs, soft restraints, hard metal handcuffs, a black box, Chubb cuffs, leg irons, belly chains, a security (tether) chain or a convex shield.”⁹⁶

Physical Restraint/Use of Force -- DOC Directives define “physical force,” as “physical contact or contact through use of an armory item/canine initiated by a staff member in response to a non-compliant inmate for the purposes of establishing, maintaining or restoring control, order, safety and/or security. Routine use of physical contact shall not be considered physical force, including the routine use of restraints.”

DOC report to the legislature in 2017 regarding the use of restraint and isolation on youth and young adults categorizes the use of force as routine or non-routine:

Non-routine Emergency Restraint —“MYI staff respond to emergency calls for assistance involving inmate(s) who are assaultive, actively combative, or posing an imminent threat to the safety/security of themselves, others, or state property.”

Routine/Non-emergency Restraint — For inmates on restrictive status, “restraints are used during transportation for visits, court appearances, showers, etc. for the safety of offenders and staff on a temporary, as needed basis.”

DOC Directive 6.5 provides that

- “the amount of force used shall be reasonable and appropriate to the circumstances based on the situation, the information in the possession of correctional personnel at the time, and the information reasonably available under the circumstances.”⁹⁷
- Staff are required to use a video camera prior to any planned use of physical force.⁹⁸
- Staff are required to attempt and document verbal intervention prior to a planned use of force.
- Staff are required to consult with a health services staff member prior to a planned use of force.
- When the inmate is secure, staff shall, whenever practical, utilize treatment staff, prior to a planned use of force.

⁹⁵ No documentation was provided regarding compliance with training requirements.

⁹⁶ DOC Directive, Number 6.5

⁹⁷ Id.

⁹⁸ Id.

DOC Directive 6.5 further defines “chemical agent” as either a Category I device, which is a “hand held aerosol dispenser;” or a Category II device, which refers to “all methods of administration other than hand held aerosol devices.”⁹⁹ Chemical agents may be used as a restraint during a planned or unplanned use of force.

Use of Force (Physical, Mechanical and Chemical) on Youth at MYI and YCI

OCA’s initial information request sought data regarding MYI’s use of physical, mechanical and chemical restraint involving youth ages 15-17 from January 1, 2017 through June 30, 2017. The response from the facility provided on August 1, 2017 stated that there were **27** instances of Restraint/Use of Force during the PUR. That initial response did not clarify whether the use of force was physical or mechanical. The information provided was incomplete, with at least two months’ worth of missing data.¹⁰⁰

OCA obtained Restraint Tracking Forms and Monthly Unit Statistics for the same 6 month time frame and found the following:

- **18** incidents of Non-Routine Mechanical Restraint Utilization and **53** instances of Routine Mechanical Restraint. These data points, gathered from incident sheets and interviews with facility administration, are not specific to individuals – if multiple youth are involved in a fight, for example, the use of force is documented as “1.”
- An additional 6 month period reviewed by OCA (January 1, 2018 through June 30, 2018) revealed **138** total instances: **20** incidents of Non-Routine Mechanical Restraint Utilization and **118** instances of Routine Mechanical Restraint.

There is no statutory or agency restriction on the use of prone (face-down) restraint of youth in DOC custody (Conn. Gen. Stat. § 46a-150). State law does not permit the use of prone restraint on minor students, and DCF and CSSD facilities do not permit the use of prone restraint on minors due to concerns regarding chest and airway compression. A U.S. Department of Education resource guide on the use of restraint and seclusion states that prone restraints “should never be used [on youth] because they can cause serious injury or death.... Any restraint or seclusion technique should be consistent with known medical or other special needs of a child.”

Source: U.S. Department of Education, *Restraint and Seclusion: Resource Document* (2012).

MYI administrators provided OCA with data regarding both routine and non-routine use of force, but multiple data submissions from the facility were discrepant and OCA found the data regarding use of force to be unreliable — DOC facility administrators acknowledged discrepancies in data collection and reporting and committed to addressing this problem going forward.

Facility staff were not able to provide consistent explanations of what constituted routine versus non-routine use of force despite the report from the DOC to the legislature in 2017 describing use of force at MYI in those terms. Staff and administrators acknowledged that different people may document use of force differently both within the facility and throughout the agency.

OCA additionally found that reports of use of force for significant behavioral incidents did not match up with the number of youth placed in restrictive housing as a sanction for incidents. For example, while facility reports often documented only 1 or 2 Use of Force incidents per month (and the DOC

⁹⁹ Id.

¹⁰⁰ As OCA sought to clarify data points with MYI facility staff, OCA was told that staff report all incidents of “Use of Force” in the facility’s monthly unit statistics report.

report to the legislature reported 0 incidents in some months), there were typically many more youth placed on restrictive housing (CTQ) status for the same time period.

Reported numbers regarding *routine* use of force do not match the number of youth or actual utilizations of mechanical restraint, suggesting again that staff track use of mechanical restraint inconsistently.

Chemical Agent Use at MYI

As referenced above, DOC Directive 6.5 permits the use of chemical agents on youth and adults, and certain personnel are identified to carry such agents on their person. The Directive requires that prior to the use of chemical agents, “the inmate’s health record shall be reviewed by a qualified health services staff member to determine whether the use of chemical agents on the inmate is medically contraindicated.”¹⁰¹

According to the Council of Juvenile Correctional Administrators--

[Pepper spray’s] use has been shunned by juvenile correctional agencies because of the harm it causes to youth and the negative impact on staff-youth relationships, the key to successful juvenile rehabilitative programming. Very few states authorize its use [in juvenile correctional programs] and in the states that allow its use in policy, most prohibit the use except as a last resort and with many conditions and few facilities put it into practice.¹⁰²

A recent article from the Juvenile Justice Information Exchange¹⁰³ indicates that as of 2018 there were only 6 states that allowed juvenile correctional officers to carry pepper spray.¹⁰⁴ 35 states have banned pepper spray in juvenile facilities.¹⁰⁵

A fact sheet regarding the use of chemical agents on juveniles authored by the Center for Children’s Law and Policy¹⁰⁶ in 2012 recommends a prohibition on the use of chemical agents on children due to potential health risks and the potential for misuse by staff. The CCLP cites research published in the British Medical Journal which noted the ill effects of chemical agents in confined spaces and areas

¹⁰¹ DOC Directive 6.5. The Directive also provides that the outcome of the health consultation shall be documented on a medical incident report and in the inmate’s health record.

¹⁰²Pepper Spray in Juvenile Facilities, CJCA, available at <http://cjca.net/attachments/article/172/CJCA.Issue.Brief.OCSpray.pdf>.

¹⁰³ The Juvenile Justice Information Exchange (JJIE) is a publication covering juvenile justice and related issues nationally. The JJIE is based at Kennesaw State University. <https://jjie.org/>

¹⁰⁴ Almasi, Aya, *California Corrections Board Approves Limits to Pepper Spray, No Change to Staff Ratios*, Feb. 14, 2018, JJIE, article found on the web at <https://jjie.org/2018/02/14/california-corrections-board-approves-limits-to-pepper-spray-no-change-to-staff-ratios/>, article cites California, Illinois, Indiana, Minnesota, South Carolina, and Texas as permitting use of chemical agents on minors in juvenile justice facilities.

¹⁰⁵ Id.

¹⁰⁶ Center for Children’s Law and Policy, *Chemical Agents in Juvenile Facilities*, (May 2012), found on the web: <http://www.cclp.org/wp-content/uploads/2016/06/Fact-Sheet-Chemical-Agents-Final-5-14-12.pdf>.

with poor ventilation.¹⁰⁷ The CCLP identified several states that have taken action to prohibit chemical agent use on juveniles.¹⁰⁸

OCA sought additional information from doctors at Yale School of Medicine regarding the impact of chemical agents such as pepper spray on minors. OCA was provided with research literature indicating that pepper spray and other irritants have been associated with various health risks and complications such as pulmonary edema and asthma.¹⁰⁹ According to literature provided to OCA by a physician at Yale, pepper spray and similar irritants, when inhaled, produce “a sensation of chest constriction with dyspnea, gagging and burning of the respiratory tract.”¹¹⁰ The effects of tear agents are generally considered transient and may dissipate quickly once removed from the source, but sensitivity to irritants is “individual and age-dependent.”¹¹¹

Chemical Agent Utilization Data--MYI

MYI reported 6 utilizations of chemical agents during the 6 month period January 1, 2017-June 30, 2017. However, OCA found additional use of chemical agents beyond what was reported. It also appears that chemical agent use, like use of force, is tracked per incident and not per individual use.¹¹²

OCA sought additional data from MYI regarding chemical agent use through July 1, 2018. The data contained discrepancies in the facility’s reports of chemical agent use.

- In May, 2018, MYI reported a total of 2 utilizations of a chemical agent as part of a “non-routine” use of force incident.
- OCA reviewed back-to-back incidents from May 30, 2018, and May 31, 2018, involving 5 youth (fighting) and 1 youth (assault). A chemical agent was used during this incident and 3 of the youth were reported to need decontamination from the chemical agent, and the facts of the incidents would not be considered non-routine under the agency’s own definition.
- 2 of the youth involved in the reviewed incidents have documented histories of Asthma – rendering the use of chemical agent even more concerning.

After reviewing this particular incident highlighted above, OCA notified DOC leadership of concerns regarding the use of chemical agent and in-cell restraint of a minor, as well as concerns with inadequate

¹⁰⁷ Id. citing Pierre-Nicholas Carron & Bertrand Yersin, Management of the Effects of Exposure to Tear Gas, 338 BRITISH MED. J. 1554, 1556 (2009).

¹⁰⁸ Id. referencing, among others, 1) The Louisiana Office of Juvenile Justice barred chemical agents in its facilities in 2007; 2) The Florida state legislature, in 2006, required the Department of Juvenile Justice to adopt policies that “prohibit the use of aerosol or chemical agents;” 3) New Jersey, in 2005, amended its administrative code to clarify that the use of chemical agents is not allowed in juvenile detention facilities; 4) New Hampshire, in 2010, passed a statute prohibiting the “intentional release of noxious, toxic, caustic, or otherwise unpleasant substances near a child for the purpose of controlling or modifying the behavior of or punishing the child” in a range of settings, including schools, group homes, shelters, detention centers, and commitment facilities.”

¹⁰⁹ Upper airway problems may include laryngeal edema and stridor. And significant eye injuries may occur, including corneal epithelial injury and kerato-conjunctivitis. Research literature provided via correspondence from Carl Baum, M.D., FAAP, FACMT, Professor of Pediatrics and of Emergency Medicine, Yale School of Medicine to the OCA, on file with OCA.

¹¹⁰ Id. citing article on Toxed.com.

¹¹¹ Id.

¹¹² For example, in May 2018 a fight amongst 5 youth resulted in use of force, including chemical agent use, on 4 of the youth. This incident was recorded as 1 use of force with chemical agent.

medical assessment and follow-up. Additionally, OCA (pursuant to responsibilities as mandated reporters) filed corresponding complaints with DCF and the Department of Public Health. OCA's complaint to DCF also shared concerns regarding the youth's prolonged isolation on the restrictive housing unit.¹¹³

CASE STUDY – TERRANCE

In one incident from May, 2018, a youth was restrained by several officers after refusing to return to his cell. He was sprayed with chemical agent twice and ultimately restrained in the prone (face-down) position. During the course of being restrained by officers, the youth swung at staff, striking a staff member. Following the prone restraint and use of chemical agent the youth could be heard on video tape repeatedly stating that he could not breathe and that he had asthma. The youth's medical record, reviewed by OCA, confirmed a diagnosis of asthma and that he was prescribed an inhaler. DOC staff could be seen on the tape moving the youth briefly to the shower to wash his face off. The video depicts the youth salivating and continuing to state that he was having trouble breathing and needed an inhaler. Both nursing and clinical staff were present during the incident, standing behind custody staff, and waiting for the youth to be stripped, changed, and prepared for in-cell restraint. At no time during the incident or its aftermath does it appear the youth's vital signs were checked and there is no record that the youth was provided with an inhaler. The initial medical incident report states that "no complaints [were] reported by inmate; no marks or injuries noted." On video the youth could be heard telling the mental health clinician that he was afraid he was going to die.

OCA pursued additional information from MYI regarding specific youth and their medical conditions, and if youth with known respiratory conditions had been subjected to chemical agent utilization. The DOC reported that at least 7 youth diagnosed with Asthma had been subjected to chemical agent spray within the last year. OCA further learned that during the 18 month (January 1, 2017 - July 1, 2018) 39% of the youth population at MYI who had experienced cell restriction had been subjected to a chemical agent.

Use of Force and Isolation at YCI

None of the 6 girls at YCI during the PUR were reported to have experienced restraint, seclusion (Confined to Quarters Status) or chemical agent spray. Girls at YCI are not confined to cells. Over the past few years, the DOC has used "cottages," to house minor girls. The cottages are a separate

structure from the main facility and are located near the visiting area. There are two usable cottages that consist of an entranceway, a bedroom, a washer and dryer and a common area. A youth may be housed with another youth. The youth cannot leave the cottage or engage in any movement on the facility grounds without escort from staff. Girls are not mechanically restrained for escort.

As recently as August 2018, 1 youth at YCI was charged with an assault on a DOC staff member and placed on Confined to Quarters status for fourteen (14) days. YCI administrators reported to OCA that the youth did not receive educational services on three (3) school days; but did receive an hour of education in the cottage on 2 days and was able to be escorted to school for 5 hours of education for the remainder of the CTQ status.

Though girls are not confined to cells, concerns about physical and social isolation still arise given the low census and site-sound restrictions on youth's movement required by federal law. At times there may be only 1 or 2 juveniles at York and therefore social interaction may be minimal.

¹¹³ DCF's Special Investigations Unit report did not address the use of prolonged isolation on the restrictive housing unit and the report did not substantiate a finding of abuse or neglect. The SIU identified program concerns regarding the lack of thorough medical assessment and response to the youth, finding that nursing staff "did not assess [youth] for the distress he expressed." OCA met with DCF's Special investigations Unit in August 2018 to further discuss these concerns. OCA recommended that DCF consider following up directly with DOC leadership regarding the deleterious impact, from a child welfare perspective, of certain policies regarding the use of force, chemical agent utilization, and the prolonged isolation of minors.

The CTQ practice at YCI differs from MYI, as the youth on CTQ at MYI are not allowed to attend school and at most are passed a school work packet underneath their cell door.

MYI – Isolation Used in Response to Youth Behavior

Temporary Isolation – 23.5 hours per day

The MYI Housing Plan (Housing Plan) provides for the utilization of Confined to Quarters (“CTQ”) status as a disciplinary response to inmates who engage in behavioral incidents such as fighting, threatening, possessing contraband, assault, and disobedience. Youth and staff often refer to CTQ Extended (defined below) as “the box.” The Housing Plan states that CTQ shall be an “alternative to the use of Segregation with the youth population,” and CTQ “will confine a youth to his cell for disciplinary reasons or for their own protection.”

CTQ encompasses four phases: Low; Moderate; High; and Extended. On Low CTQ facility policy provides that a youth remain in the facility uniform, retain personal property, attend school and services, but not attend general population recreation or work. Youth on High or Extended CTQ are moved to a “designated CTQ out cell,” placed into a jumpsuit, and not allowed to retain property. Youth on Extended CTQ are not allowed to attend the school facility or rehabilitative programs. OCA found that no youth on CTQ Extended was provided with educational tutoring or other direct instruction.

Maximum sanctions on High or Extended CTQ status are permitted for up to 5 days with discretion for “Extenuating Circumstances.” OCA found that several youth were placed on CTQ Extended for longer than 5 days (see data below).

The Housing Plan provides that a Behavior Plan may be created for youth who develop a “disciplinary history,” and to facilitate a “step-down” to the general population.¹¹⁴ A Behavior Plan should outline the youth’s behavior and identify what he needs to do “to get back on track.” OCA found that no behavior plans were created for boys on CTQ during the PUR.¹¹⁵

OCA’s review of youth-specific records regarding disciplinary reports and accompanying CTQ-Extended Sanctions revealed the following:

From January 1, 2017 through July 1, 2017, there were **74** incidents of youth placed on CTQ Extended (“the box”), hereinafter “CTQ.”

- a. There were a total of **41** youth placed on at least one instance of CTQ. (Facility census of 15-17 year olds was comparable to the same 6 month period in 2018).
- b. Range of CTQ confinement was **1** day to **15** days.
- c. **18/41** youth were placed on CTQ on at least 2 occasions.

OCA’s investigation found the following conditions of confinement for youth on CTQ.

¹¹⁴ MYI Housing Plan provides that the Behavior Identification Plan “shall be implemented within a team setting and will be used to intervene on negative behavior and develop strategies to assist the inmate with improving his behavior.”

¹¹⁵ Staff reported to OCA that behavior plans had not been developed “for years,” and that the facility lacked resources for developing individualized plans and interventions.

- **Extensive Isolation – Youth** on CTQ were placed in cell-confinement in MYI’s restrictive housing unit for juveniles for 23.5 hours per day.
- **No School** – Youth were not provided educational tutoring or access to school.¹¹⁶
- **Mechanically Restrained When Out-of-Cell** – Youth were permitted out of their cells for 30 minutes each day, during which time they were handcuffed and permitted to make a phone call and/or shower.¹¹⁷
- **No Social Interaction** – Youth were not permitted to socially interact with other youth.
- **Eat Alone** – Youth ate in their cells.
- **No Behavior Plans/Supports** – Youth were not provided with individual behavior plans to support transition from CTQ to the general youth population. Staff reported to OCA that while such plans might be a good idea, they had not been done in years due to limited resources.

OCA continued to examine utilization of CTQ during 2018 and found an **increase** in sanctions over a 6 month period.

From January 1, 2018 through July 1, 2018,¹¹⁸ there were **96** incidents of youth placed on CTQ Extended.

- a. There were a total of **56** youth placed on at least one instance of CTQ.
- b. The range of CTQ confinement was **3** days to **30** days.
- c. **24/56** youth were placed on CTQ on at least 2 occasions, with a range of **2** to **6** separate instances of CTQ confinement each.
- d. Youth on CTQ were permitted out of cell for half an hour per day (handcuffed), were not provided with tutoring/school, were not provided behavior plans, and were not allowed access to rehabilitative programming.

Months-Long Isolation for Certain Youth at MYI – Security Risk Group (SRG) Status

DOC Directive 6.14 provides that SRG is a months-long program of restrictive housing for “inmates, designated by the Commissioner, possessing common characteristics, which serve to distinguish them from other inmates or groups of inmates and which as a discrete entity, jeopardizes the safety of the public, staff or other inmate(s) and/or the security and order of the facility.”¹¹⁹

OCA finds that SRG, which consists of “placing an inmate on restrictive housing status following a determination that such inmate can no longer be safely managed within the general inmate population of the correctional facility,” meets the state statutory definition of administrative segregation, and therefore is not permitted by Connecticut law.

¹¹⁶ A youth may be provided academic work sheets. Youth may accept or refuse this work.

¹¹⁷ The youth are handcuffed during escort to and from the shower but not handcuffed in the shower.

¹¹⁸ This time period is different that the PUR for other data points as OCA initially was told that cell confinement was not used at all, and therefore data regarding these issues were developed as OCA’s review continued.

¹¹⁹ DOC Directive § 6.14

Directive 6.14 describes SRG as a “method, by which inmates designated as SRG Members, after successful completion of a structured 5 phase program, may be reintegrated into General Population.”¹²⁰

At MYI the SRG program and its five phases is used as a gang intervention curriculum and a methodology for ensuring the safety of staff and other inmates in general population by separating out inmates who are considered to be particularly threatening or assaultive. The typical method by which a youth at MYI is designated as SRG status is through his active affiliation, detected or declared, as a gang member. Depending on the nature of the youth’s affiliation and based, in part, on whether the youth is determined to have engaged in assaultive or threatening behavior in confinement as a result of that affiliation, the youth may be designated to the SRG program beginning on either Phase 1 (the most restrictive) or a less restrictive Phase.

Youth placed on SRG status Phase 1, which continues for at least four months,¹²¹ are confined to an SRG cell on the restrictive housing unit for juveniles, the same unit that youth on CTQ are confined.

During SRG Phase 1, the youth is kept in restraints for all out-of-cell movement,¹²² including phone calls and movement to and from showers and the phone. In-cell programming, which consists of work sheets specific to the SRG program, begins during Month 2 if the youth is free of disciplinary reports. The youth is permitted 1 hour of out of cell time a day, handcuffed, and this time must include phone calls, bathing, and movement. There is no access to recreation equipment, and typically no access to fresh air. Youth eat in their cells and are not permitted to engage with other youth, though youth have been observed shouting to each other from their cells.

Pursuant to DOC policy, because youth on SRG status spend most of each day in their cells, they must be directly observed by correction staff “not less frequently than every 15 minutes,” and “living breathing flesh shall be observed.”¹²³

Pursuant to DOC policy, SRG Phase 2 lasts a minimum of 3 months, during which time a boy may engage in group programming once he is incident free and completes all in cell programming (minimum of 30 days on Phase 2). During OCA’s review however, no youth on SRG 1 or SRG 3 was permitted to participate in group programming available to others. There were no youth on SRG 2 during OCA’s site visits to the facility.

Progression through the SRG phases is based on the youth’s behavior and compliance with SRG expectations. If the SRG program is not completed prior to the youth’s discharge and the youth re-offends and is returned to the DOC custody the youth or now young adult will return to SRG segregation automatically. If the youth is over 18, he will be transferred to an adult facility to serve out the full SRG level of confinement.

DOC administration shared their belief that SRG completers show a marked decrease in gang related activity but was not able to provide OCA with supporting research or departmental outcome data.

¹²⁰ Id.

¹²¹ SRG Manual for MYI.

¹²² Youth on SRG 2 and 3 are also only allowed 1 hour of out-of-cell time on the unit, but they do not have to be in restraints during this hour.

¹²³ Id.

OCA Review of Conditions for Youth on SRG Status

OCA reviewed data regarding the use of SRG, examining youth-specific records, incident reports, education and treatment logs, and other information relevant to the use of restrictive housing for youth, the reasons for the youth's SRG designation, and the impact of SRG designation on youths' access to educational and rehabilitative programming. OCA also conducted numerous site visits to the SRG/CTQ unit and interviewed youth and staff. OCA found the following:

- **Number of Youth on SRG** – There were **14** youth placed on SRG status during OCA's review (through July 1, 2018), which is just under 10 % of youth admitted to MYI during the timeframe reviewed.
- **Youth Placed on SRG due to Gang Affiliation/Behavior** – Youth were generally placed on SRG status due to information, detected or declared, that the youth were/are gang-affiliated. Sometimes the youth in question also engaged in assaultive behavior prior to SRG placement that DOC staff determined was the direct result of gang affiliation.
- **SRG is Months of Restrictive Housing** – The range of SRG confinement (for youth who completed SRG) was 5 months to 15 months. Certain youth turned 18 while on SRG status.
- **No Behavior Plans for SRG Youth** – Similar to youth on CTQ, no youth on SRG had an individual behavior plan.
- **Limited Education Services for SRG Youth** – How education was delivered to youth on different phases of SRG varied during the course of OCA's review, but youth received a maximum of 1 - 2 hours of education services per day, typically one-on-one.¹²⁴
 - Youth on SRG could refuse to leave their cell for education, and there is no documented intervention for persistent school refusal.
 - Youth on SRG Phase 3 were permitted to be escorted to the school building and were permitted 1:1 tutoring with a teacher at that location, typically from 8:45 a.m. to 10:30 a.m.¹²⁵ These youth, like those on SRG Phase 1, were then returned to their cells for the remainder of the day, with 1 hour permitted for out of cell time, to be used for phone calls (3 calls per week are permitted) or hygiene.
- **IEPs/Special Education Plans Changed for Youth on SRG** – Youth-specific education records reviewed by OCA indicated that the education plans (IEPs) for youth on SRG were changed to reflect a marked reduction of educational hours¹²⁶ “due to a bona fide safety, security and compelling penological interest.”

¹²⁴ Education administrators stated that tutoring was provided to two SRG Phase 1 youth (2018 data) from 12:30 to 3:30 but acknowledged that due to behavior issues, the youth split that time. Youth and staff interviews, as well as observation by OCA staff, confirmed that a teacher, when available, comes onto the SRG unit at 1 p.m. and typically leaves prior to 3 p.m. OCA was initially told by administration that youth on SRG received 4 hours per day of education, but records, along with staff and youth interviews, did not verify this level of service delivery. OCA was also told by correctional staff that unit entry-exit logs documenting the times the teacher came to the restrictive housing unit were not a reliable source to confirm service delivery.

¹²⁵ Per youth and staff interview. Logs provided by the school do not provide documentation of hours provided, only what the duration of a.m. or p.m. slots are for education generally. Thus educational administrators stated that the SRG Phase 3 youth are provided education from 8 a.m. to 11 a.m. but interviews with staff and youth indicate the youth left the SRG unit at 8:45 and returned at approximately 10:30.

¹²⁶ The IEP for one youth designated SRG Phase 3 called for 3 hours per day of educational services. This recommendation constituted a reduction in the provision of education services. However OCA found that this youth did not receive even this level of service. The IEP for another youth designated SRG 1 was changed to reflect reduced hours of 1 hour per day of general education services and 15 minutes per day of special education services. The education plan of a third youth

- **Youth on SRG Meet Definition of “Chronically Absent” from School Services and OCA Found Data Discrepancies** – OCA examined MYT’s attendance data for various youth on SRG status during 2018, and found a range of documented attendance rates — 50% to 73%, with absences for “Custody,” “Sick,” “Teacher absence,” and simply “Absent.” OCA developed concerns about the reliability of the facility’s attendance data given significant disparities contained in the records, and staff’s assertion that unit entry-exit logs are not reliable.¹²⁷
- **No Rehabilitation Programming** – No youth on SRG phases 1 through 3 were permitted to attend rehabilitative programming available to youth in general population: e.g., substance abuse treatment, anger management, life skills, or domestic violence programming.
- **Few or no Visits** – Youth on SRG status during the PUR received few or no visits from family or other resources.
- **Clinical Intervention is Not Built into the SRG system** – Youth may ask for clinical support, but structured access to clinical contacts is generally dependent on the youth’s pre-existing Mental Health Score or a direct request from the youth.¹²⁸ Facility administrators told OCA that clinical staff tour the SRG/CTQ unit every day, and if a youth needs he is offered the opportunity to ask for it. As stated elsewhere in this report, during OCA site visits and video reviews, clinical staff were observed coming to the unit and walking by individual closed cells and looking through the window at youth. During interviews, youth told OCA that clinical staff “keep it moving,” and that if youth are sleeping they may not know that clinical staff has been there. One youth (identified with a Mental Health Score of 3) stated that his assigned clinician greets him personally during these checks. OCA’s review of documentation in youth’s records did not typically include documentation of mental health contacts conducted during the “check-in rounds” unless the youth was classified as a Mental Health 3 or 4.

Interviews with Youth on SRG

Youth confirmed that the SRG system requires them to spend most of each day in their cells. They stated that they have little access to school time and no access to rehabilitative programming. Certain youth acknowledged that they sometimes refused to go to tutoring but also claimed that they were sometimes identified as refusing when they were really available for school but not let out of cell or when no teacher would come to them.

No youth interviewed by OCA reported receiving visits during SRG status; one youth told OCA that he didn’t know when visits were. The same youth reported that he felt he was “going crazy” on SRG, and that he resorted to “talking to himself,” because he was not allowed to talk to anyone else. He reported that he was given the SRG curriculum packets to work on independently and that he handed them in and got them back with little interaction. Another youth reported to OCA that he would not allow himself to think about his level of confinement because he could not bear it. Certain youth on

who was designated SRG Phase 3 was also changed to reflect provision of 3 hours per day of education services (as opposed to 5), though as stated above interviews with youth and staff as well as OCA observations do not reflect that any youth on SRG was receiving even this level of education service on a daily basis.

¹²⁷ Example: one youth on CTQ Extended for 17 school days was marked as present in school during this time period, though the youth did not attend school and was not provided educational services on the restrictive housing unit.

¹²⁸ See following Section of this Report - Access to Mental Health Treatment.

CTQ Extended or SRG Status were observed by OCA and MYI staff not to be showering or addressing basic hygiene needs on a regular basis.

Interviews with Staff/Administration Regarding Restrictive Housing for Youth

OCA discussed the use of SRG and CTQ extended with facility administration and agency leadership on multiple occasions. While acknowledging the priority and importance of ensuring a safe and secure environment for all staff and youth, OCA conveyed significant concerns regarding utilization of long-term isolation as a behavior/population management tool. Specifically, OCA expressed concerns that 1) state law does not permit the use of restrictive housing for minors in the wake of a 2017 law limiting the use of administrative segregation; 2) youth on SRG lack access to rehabilitative programming and individual behavior plans; and 3) prolonged cell confinement is harmful to youth's development and mental health.

Facility administrators and staff stated that they do not agree with OCA's finding that either SRG or CTQ constitute solitary confinement because they do not include prolonged sensory deprivation. Administrators and senior staff at MYI stated that CTQ and SRG are needed as security and population management measures for adolescent offenders, and that youth who wind up in restrictive housing are there because they pose a substantial security threat to staff and the general population of youth. Staff stated that youth are, in general, more difficult to supervise, and that there are typically more fights among youth, and that sometimes youth "don't even know why they are fighting." Staff cautioned that they would not be able to conduct any programming in the facility if staff and youth could not be kept safe, and that restrictive housing is a way to control the environment so that other youth can be safe and attend programming. Staff acknowledged that there are resource limitations and that there are not as many programs for youth as staff would like, and that there are inadequate resources to conduct individual behavior planning for high-need youth.

MYI administrators acknowledged that correction staff are not trained in an adolescent custody or treatment model, and staff receive no training on how to address adolescent behavior and diffuse crises with adolescents using developmentally appropriate measures.

Staff stated that the ultimate goal of SRG is for each youth to renounce any gang affiliations, but acknowledged that the program does not typically achieve that goal. The collateral goal is one of deterrence, i.e. for youth to learn from the prolonged period of deprivation that they want to avoid behaviors that would return them to restrictive housing status. Administrators and staff did not feel that the prolonged use of cell confinement or lack of access to peer interaction and programming had a negative impact on youth's development or mental health. Staff reiterated that the restrictive measures are designed to be punitive and uncomfortable for youth, but not so punitive as to be harmful. One MYI official stated that he wanted "to see what [youth x] is like after 30 days" in CTQ, expressing some hope that the boy would improve his behavior and compliance with facility expectations. Staff expressed willingness to review recommendations from national experts regarding alternative methods of promoting adolescent rehabilitation without compromising staff and facility safety.

OCA also presented its concerns about reliance on CTQ and SRG to agency leaders who responded that they would examine the restrictive housing practices further, including reviewing the practices and penal discipline code with the Attorney General's Office and consulting with juvenile and criminal justice experts to consider alternative models for establishing facility security without resorting to prolonged cell confinement of youth.

Staff and youth safety in any correctional environment are of paramount importance. Acknowledging this, OCA remains deeply concerned about the use of segregation for minors as a behavior management tool given the resulting loss of access to critically needed programming and healthy social interaction, and the deleterious impact of isolation on youths' development and mental health. It is OCA's finding that all of the youth in CTQ and SRG are at risk for mental health deterioration and are not receiving adequate services. Several of the youth placed on SRG have histories of disruptive, threatening or assaultive behaviors and effective behavior management strategies and rehabilitative programming are essential to assist them, reduce their negative behaviors, and decrease their risk of recidivism. These youth need engagement, mentorship, and intensive clinical/rehabilitative programming. An effective adolescent model will provide for an intensive level of service without compromising youth or staff safety.

C. ACCESS TO MENTAL HEALTH TREATMENT

Staffing at MYI

MYI administrators reported to OCA that the clinician-to-patient ratio for young adults in the facility is 21:1 and 7:1 for youth in the facility. Among the units housing youth, clinicians' on-site weekly schedule is Monday-Friday, 5:00 pm to 12:00 am. Monday-Thursday, and includes:

- LCSW is available for group facilitation, individual counseling, urgent requests, and Emergency Crisis Intervention services.
- Emergency Crisis Intervention Services are available to all youth and young adult inmates 24/7 and when the unit clinician is not available.
- DOC reported that none of the clinicians are assigned solely to the juvenile units and that 40% of the juveniles are actively engaged in MH services (this characterization was not defined).

Mental Health Classification System in the DOC: Mental Health (MH) Scores 1 – 5.

After intake and mental health assessment, the DOC provides each youth with a "mental health score" outlining the youth's history and current need for treatment and intervention. Correctional Managed Health Care (CMHC), in cooperation with the DOC, published a guide to mental health classification.

- MH 1—youth has no history of prior mental health treatment nor current medical needs;
- MH 2—youth has a history of prior mental health treatment but does not have any current clinical needs;
- MH 3—youth may or may not be prescribed medication by a psychiatrist or APRN; youth will have a primary clinician who will see him/her typically bi-weekly unless a different treatment frequency is clinically indicated;
- MH 4—youth typically has more severe history of mental health treatment, prior hospitalizations, suicide attempts or self-injury, and more frequent mood or psychotic disorder. These individuals are seen weekly by their clinician and are most frequently on prescribed psychotropic medication. If a youth with a designation of MH 4 is placed on "Confined to Quarters" status, the youth is monitored twice a day for any potential changes in mental status.
- MH 5—youth is currently residing in the infirmary – a skilled nursing setting for mental health monitoring – due to suicidal ideation, potential self-injury, substance detoxification and withdrawal, psychosis, or risk of decompensation.

Per DOC staff, upon intake each youth receives a mental health assessment, a mental health initial evaluation, and a suicide risk assessment. Mental health scores are assigned and services are delivered as indicated by the MH score. Per the DOC administration, a comprehensive psychiatric history is obtained for all incarcerated youth, which includes collateral contact with former treatment providers and family. This information is also used to determine the patient's treatment needs.

Utilization of Mental Health Services for youth (15 to 17 years old) at MYI—DOC Information and OCA Review

OCA's review of **53** youth confined at MYI in May, 2017, revealed the following mental health scores for the juvenile population:

- MH 1: **12** youth
- MH 2: **17** youth
- MH 3: **20** youth
- MH 4: **4** youth

Based on OCA's review of youth-specific records and OCA staff's participation in regular meetings regarding case planning for incarcerated youth at MYI, OCA finds that mental health evaluation is not consistently comprehensive for youth, in part due to variability regarding how information is shared and transmitted to MYI from other custodial and treatment settings.

Finding- Most Youth Receive Little or No Individual Clinical Treatment at MYI

Despite the national data regarding the prevalence of mental health disorders among incarcerated children and the number of boys at MYI with current or historical mental health diagnoses, based on the data reviewed by OCA, the majority of incarcerated children were classified by the DOC as either having no history of mental health treatment or not presenting with any current clinical needs. Only 2 boys confined at MYI in May 2017, for whom Mental Health Scores were provided to OCA, were identified as in need of weekly mental health counseling.

OCA made an identical finding in 2016 as part of a presentation to the state's JJPOC. Of the 74 boys incarcerated at MYI in July of 2016, more than half were identified as not requiring individual clinical treatment, although 71 presented with a current or historical mental health diagnosis. Only 3 boys were classified as requiring weekly contact with a clinician. At the time of OCA's 2016 review, DOC administrators provided information that clinical staffing in the facility is limited and that typically, there were only two DOC clinical professionals available, from 8 a.m. to midnight, for the entire facility population of approximately 600 adolescents and young adults.

CMHC reported that **59** juveniles requested Mental Health contact during the PUR. CMHC was unable to provide data regarding the total number of unique individuals seen, time lapse between request and contact, and whether the youth's mental health score changed post contact.

Group Programming—Access and Utilization

The DOC did not provide data regarding utilization of group programs during the PUR. OCA reviewed the entire service utilization record for 50 youth confined at MYI during the PUR, including a 24 month look back, which led to the following findings-

- Unlock Your Thinking¹²⁹— a brief, non-clinical, 4-session program.
Over a 24-month period, 21 youth participated.
- Voices— a non-clinical, 15-session program designed to use volunteer support to broaden children's understanding of and sensitivity to the impact of their offenses on others.
Over a 24-month period, 19 youth participated.

¹²⁹ This group includes 4 sessions, which according to the program description, is aimed at "addressing the ingrained pattern of criminal thinking." TCU Institute of Behavioral Research, available on the web at: <https://ibr.tcu.edu/manuals/description-unlock-your-thinking-open-your-mind/>

- New Direction--Addiction Services Program to meet the needs of sentenced and un-sentenced children for short-term drug and alcohol education intervention.
Over a 24-month period, 13 youth participated.
- Thresholds— a counseling system specifically designed for delivery by trained volunteers.
Over a 24-month period, 4 youth participated.
- Life Skills—24-hour curriculum that discusses educational subject matter in nutrition and better hygiene, managing money, and social-behavioral subjects.
Over a 24-month period, 16 youth participated.
- Domestic Violence Intervention—designed for youth who have committed a domestic violence offense. Successful completion of this program is a requirement for youth who enter into the DOC's community-based transitional supervision program for domestic violence offenders.
Over a 24-month period, 2 youth participated.
- Anger Management—10-week program designed for adolescents to learn anger management and coping skills.
Over a 24-month period, 10 youth participated.
- Tier 2 – an addiction services group for adolescents.
Over a 24-month period, 2 youth participated.

Individual youth participation in group programs at MYI-- number of programs participated in by each youth from date of admission through July 1, 2018.

Programs Participation	No. of Youth	Length of Confinement
0 Programs	13 Youth	17 months
1 Program	11 Youth	20 months
2 Programs	13 Youth	19 months
3 Programs	6 Youth	20 months
4 Programs	7 Youth	27months
5 Programs	3 Youth	21 months

OCA found that more than half of the youths incarcerated at MYI during OCA's review participated in zero or 1 program, with an average period of confinement to date (July 1, 2018) of 18.6 months.

OCA made a similar finding during its 2016 review of youth incarcerated at MYI. Of the 74 youths incarcerated there in July, 2016, just under half did not participate in group programming. Many of these youth were un-sentenced and their range of confinement was 4 to 19 months. Reasons for non-participation vary, but include refusal by the youth, disciplinary sanctions, availability of staff, and lack of participation requirements.

Clinical Staffing at YCI

YCI administration reported to OCA that the facility has 1 clinician for every 14 – 28 clients. The clinicians' weekly schedule is Monday – Friday, 5:00 p.m. to 12:00 a.m. A Licensed Clinical Social Worker is available Monday – Thursday to facilitate group programming, individual counseling, urgent requests for clinical contact, and Emergency Crisis Intervention. Emergency intervention is reportedly available to all youth and young adults, 24/7.

Mental Health Scores/Access to Individual Clinical Therapy at YCI

YCI reported to OCA that staff conducts a MAYSI assessment/suicide screen as well as a mental health initial evaluation upon intake for all incarcerated youth, and Mental Health Scores are assigned and services delivered as indicated by the score. A comprehensive psychiatric history is obtained for all youthful offenders.

OCA's review found that all of the 6 females at YCI were, at some point during their confinement, designated as a MH 3 or higher.¹³⁰ All of the girls, regardless of score, received individual counseling from a clinical social worker, one session every week or every two weeks.

Programming at YCI for Girls

YCI administration reported to OCA that "YCI shall ensure that adequate programming services are offered to offenders ages 14¹³¹-17." YCI administrators initially reported that youthful offenders participate in all groups weekly, with a rate of 100% attendance. Closer review of the girls' records by OCA revealed that utilization of services was inconsistent and variable, and this data was discussed with YCI administrators.

During the PUR, female youth participated in the following programs:

- Sisters Standing Strong: groups are peer led support groups that are offered in most of the un-sentenced units. The focus of these groups is to provide support, to offer assistance in coping with stress related to incarceration, and encourage positive change by other women role models.
- Start Now: a 32 session group designed to cover a wide range of coping skills, including relationships and emotions.
- Supportive Therapy: This group consisted of having the women do check ins, support on any topic the women needed from issues at home or at YCI to conversations around substance abuse and mental health issues. The importance of this group was for the women to be supportive in positive ways and to teach and learn from each other.
- Book club: This group is based upon the inmates all reading a book from the library and discussing as a group the book and it how it might relate to themselves, what lessons might be taught from the book and how it might relate to the inmate and society.
- Mentoring;
- Seven Challenges.
- Good Intentions, Bad Choices

The frequency of participation varied by youth given admission dates and other factors, including their clinical instability and staffing issues. Certain programs are not required until a youth is sentenced. All six of the youth whose files were reviewed by OCA during the PUR were awaiting sentencing. All female youth are now assigned a mentor while incarcerated. The mentor is chosen from the adult population.

The youth at YCI receive programming both separately and with other youth who are over 18 years old. Access to program participation is affected by the availability of staff to supervise the youth

¹³⁰ Only 1 youth was initially given a Mental Health Score of 1, which was subsequently increased to a 3.

¹³¹ Only minors age 15 and above may be transferred to an adult correctional facility.

offenders due to federal regulation. YCI administrators reported that youth participate in at least one group weekly, and can participate in more if staffing allows and groups are being conducted.

In reality, youth incarcerated at YCI experience significant isolation due to their small numbers and these requirements for separation from the “adult” population.

DOC administration reported to OCA that they “strongly believe that mental health services and non-academic programming at MYI and York meet the needs of the population.”¹³²

D. ACCESS TO EDUCATIONAL PROGRAMMING

Performance measures for USD 1, and for MYI and YCI specifically, can be found on the State Department of Education website.¹³³ The USD 1 typically offers academic classes toward the General Education Development (GED) CT State High School Diploma. In certain cases it is possible to coordinate with a student’s local education agency (LEA) to assist in completing the necessary credits or seat time in order to count toward a local high school diploma from the home school.

The following was provided to OCA by the USD 1 Superintendent:

When a student enters the facility, an individual intake interview is conducted. The school staff member conducting the interview channels each student to the next step in the assessment process. A student with English as a Second Language (ESL) is assessed by an ESL instructor. If it’s determined that the student would best benefit from receiving instruction from an ESL teacher, he is placed accordingly. If a student is an emerging reader, he is assessed by an instructor who specializes in lower level learners. We use two standardized tests, the Test of Adult Basic Education (TABE) and the Employability Competency System (ECS). The TABE provides grade level equivalencies in reading, math, language and spelling. These scores help determine a student’s strengths and the areas that need to be strengthened. The ECS test helps determine a student’s employability strengths. Upon arrival in the individual classrooms, teachers administer their own assessments to determine students’ aptitudes. Just this year, we began administering the CMT test and CAPT Science.

If a student is identified as special education, he will receive triennial testing every 3 years. Depending on where the student is in this three year period, he may be tested as part of the PPT process while he is at MYI. The PPT team, in collaboration with a parent or guardian, would determine which assessments would be best suited to determine if a student continues to qualify for special education. Often, academic and cognitive testing is conducted. Behavior rating scales are also often used.

Students under the age of 18 attend school for 5 hours a day, unless a specialized plan has been developed.

A student under the age of 17 may participate in vocational education. Because students attend a full day (5 hours), attendance in a vocational program would take the place of an academic

¹³² Letter to CA Eagan from DOC Commissioner Semple dated November 8, 2018, on file with OCA.

¹³³ http://edsight.ct.gov/Output/School/HighSchool/3361115_201617.pdf.

area. Students are also able to explore vocational education to assess interest without being enrolled in a specific vocational program.

MYI officials told OCA that “While MYI does have vocational opportunities, it is not routine practice to have the juvenile offender population participate in vocational services. This may be done on an individual basis based on an identified need or concern with a particular youth, but these opportunities are mainly for the over 18 year old population at MYI.”

Attendance Concerns at MYI

USD I’s recent student performance report to the CSDE included data indicating that 37.9% of students at MYI were “chronically absent” as that term is defined in state law, meaning they missed at least 10% of the total number of days enrolled in the school year for any reason.

OCA reviewers found discrepancies between the data provided to OCA by DOC administrators and data compiled by OCA from a review of youth-specific education records. OCA examined education records for twenty-one (21) youth incarcerated at MYI during the PUR to review attendance documentation for both morning and afternoon school sessions. OCA calculated the number of missed sessions per youth along with the documented reasons for the missed sessions. Youth in the sample group had a higher rate of absenteeism than what was reported to OCA. MYI maintains attendance data for morning classes and afternoon classes. OCA examined the 21 youths’ records to determine at what rate each youth participated in a full day (5 hours maximum) of school. OCA’s analysis found that on average, youth participated in a full day of school between 14 and 72% of the time.

OCA Findings Regarding Sampled Youth’s Rate of Full-day Participation in School

Youth 1	72 %
Youth 2	67%
Youth 3	65%
Youth 4	64%
Youth 5	61%
Youth 6	58%
Youth 7	57%
Youth 8	57%
Youth 9	56%
Youth 10	56%
Youth 11	56%
Youth 12	51%
Youth 13	50%
Youth 14	47%
Youth 15	46%
Youth 16	45%
Youth 17	43%
Youth 18	42%
Youth 19	40%
Youth 20	36%
Youth 21	14%

- OCA broke down the portion of absenteeism that corresponded to the morning school session and the portion that corresponded to the afternoon session. For almost every youth, the percentage of missed class was higher in the afternoon session, with the majority of missed classes attributed to “teacher absence” or “classes not scheduled.”

- Reasons for student absenteeism included: “teacher absence,” “absence (generic),” “custody,” and “class not scheduled.” The reason for a generic “absence” or “custody” absence was often unclear, and the use of the code terms appeared inconsistently in students’ attendance records. While the facility utilizes scheduled and unscheduled lock-downs during the year as part of its security procedures, lock-downs did not account for the majority of missed educational days.

The Superintendent of Schools for U.S.D.-1 and the facility’s data analysis staff reported to OCA that U.S.D.-I had not been counting certain absences as reportable, including

missed classes for reasons such as: Teacher Absence (T) or Custody (C). OCA pointed out several youth that MYI documented as having excellent attendance but that OCA's review of the actual daily record indicated this was not the case. USD-I administration stated that they would review and improve their attendance record keeping. The facility reported to OCA that when a teacher is out or leaves for any reason or a class is not scheduled the youth is not afforded education either for the full day or a half of the day. MYI lost their substitute teachers in recent years. The data suggests that this is one of the periodic reasons youth are not participating in school and remain on the unit.

MYI also reported to CSDE that it does not suspend any students.¹³⁴ USD-I's position is that when a youth is removed from school for behavior reasons he is removed by facility custody staff and not by the teacher. While OCA understands that this distinction is due to the nature of the facility, since MYI custody staff are in charge of all movement, if a student is removed from the classroom and brought back to the unit due to behaviors and risk factors demonstrated in the classroom, then the school removal should be recorded as a suspension. USD-I administrators indicated that they were not going to change their documentation practice, insisting that they do not suspend students.

OCA also finds that USD-I practices regarding school removal and documentation indicate that school administrators have not been compliant with IDEA discipline procedures because some youth have been repeatedly removed from class, sometimes for days at a time, and there have been no IDEA-required meetings (such as a manifestation PPT) to address the school removals and how a youth's specialized needs, be they emotional or learning, may contribute to the youth's behavior. USD-I administrators reported that they had not conducted any manifestation determination meetings during the PUR.

OCA was also concerned that not all potentially eligible youth were identified as qualifying for special education and related services. USD I's reports to CSDE indicate that as of October 1, 2016, **42.9%** of students enrolled at MYI's school were identified as having disabilities. OCA notes that this percentage is substantially lower than the percentage of youth at CJTS who were identified by USD-2 administrators as special education eligible during the last two school years,¹³⁵ **61%** and **65%** respectively. OCA would not expect this rate to go *down* as youth move deeper into the criminal justice system.

Youth-Specific Education Records at MYI

OCA reviewed ten (10) youths' education records to learn more about the youths' identified disabilities, their relevant special education needs, and to understand each youth's access to special education services. OCA reviewed each youth's education record (**9** youth had an IEP, **1** youth had a 504 plan) from his previous school district as well as the records developed for the youth at MYI. OCA found the following:

1. Several students' documented access to special education hours dropped substantially after admission to MYI and enrollment in USD I.
 - Youth 1, who has an identified educational disability of "Multiple Disabilities," received **33.75** hours per week of special education services in his prior program. This declined to

¹³⁴ See also MYI School Profile and Performance Report for School Year 2016-17 filed by USD 1 officials and which can be found on the CSDE website:

http://edsight.ct.gov/Output/School/HighSchool/3361115_201617.pdf.

¹³⁵ <https://portal.ct.gov/SDE/Performance/EdSight>.

- 1.15 hours per week after admission to MYI. The youth received additional general education service hours.
- Youth 2, who has an identified educational disability of “Emotional Disturbance,” received **15.75** hours per week of special education services in his prior program. This declined to **1** hour per week after admission to MYI, along with general education service hours.
 - Youth 3, who has an identified educational disability of “Emotional Disturbance,” previously attended a specialized education program in the community, where he received **30** hours per week of special education services. This declined at MYI to **1.15** hours per week of special education services and 1 hour per month of counseling supports. He also received general education service hours.
2. For youth in the general population at MYI who were subsequently designated to the SRG Unit, their IEPs were further changed to reflect additional cuts in education service hours.
 3. Education records and evaluations reflect that all youth whose records were reviewed present with extensive educational deficits and profound need for special education and related service delivery. Evaluations reflected that these youth have needs across all academic and functional domains, yet receive relatively few special education service hours and extremely limited delivery of related services such as counseling and transition support. No youth whose IEP was reviewed received speech and language support or occupational therapy, although such services may be needed by students who have multi-disciplinary developmental disorders and academic deficits. USD 1 administrators had previously reported to OCA that they do not have access to speech and language pathologists or occupational therapists on staff but that they have the capacity to contract out for such services when needed. When OCA inquired further, USD 1 administrators acknowledged that no student was receiving these services.
 4. Relatively few students received vocational education during a 12-month period of review, although many students are entitled to transition programming under IDEA. Between July 1, 2016, and June 30, 2017, MYI administrators reported that only **14** students under age 18 received any vocational education hours.

OCA concludes that the findings above are the result of a lack of resources and, to some extent, facility population management protocols.

Education at YCI

The school at York Correctional is also part of the USD I. YCI officials reported the following to OCA:

- YCI School typically offers academic classes toward the General Education Development (GED) CT State High School Diploma. In certain cases it is possible to coordinate with a student’s local education agency (LEA) to assist in completing the necessary credits or seat time in order to count toward a local high school diploma from the home school. Generally the USD I School Counselor or School Psychologist will make the contact with the LEA to determine the feasibility of this process and then maintain contact until such time as the work is complete.
- York School offers vocational classes. At the time of this request, these included Business Education Technology, Culinary Arts, Cosmetology and Hospitality Operations Technology.
- Classes are held Monday through Friday from 8:30 am to 11:00 am and then from 11:45 a.m. to 2:30 p.m.

Youth attend school with the over 18 population at YCI. They are escorted to the school and efforts are made to keep them in close proximity to the teacher, distanced from older students.

Student Attendance at YCI

YCI had 2 students under the age of 18 who began school on September 6, 2016. There have been no suspensions or removals from school programming since that time.

During the time of enrollment through June 30, 2017, there were 168 days expected. One youth missed 17 days and the second missed 15 days for the following reasons: Court, Legal or Facility Security.

A third student, age 16, began school on May 10, 2017. From that time through June 30, 2017, there were 30 school days scheduled. She missed 7 days due to Legal or Facility Security reasons.

A fourth girl was admitted to the facility on June 28, 2017, and began educational services in July.

E. ABUSE/NEGLECT AND MANDATED REPORTING

OCA's review of child welfare records revealed that there were no reports made regarding suspected abuse or neglect of youth at MYI or YCI between 2015 and October 1, 2017, by any DOC or DCF staff member.¹³⁶

There is no independent ombudsman for youth incarcerated in adult facilities, and though DCF maintains office space at MYI and YCI, DCF is present for the purpose of assisting with DCF-committed youth treatment and discharge planning. The DCF liaison does not systemically meet with incarcerated youth to identify or address concerns of maltreatment.

MYI facility administration reported to OCA that MYI follows an Administrative Directive (6.6) on "Reporting of Incidents" and staff in the building who are mandated reporters are expected to generate a DCF report, in addition to a DOC incident report, and make hotline referrals whenever there is a report of suspected child abuse or neglect.¹³⁷ DOC administrative directives do not include specific reference to mandated reporting to DCF.

YCI administrators provided the same response as MYI.

F. ACCESS TO FAMILY CONTACT/FAMILY ENGAGEMENT

MYI

Non-contact visits for the General Population at MYI, approximately 500 individuals under the age of 21, are offered during the week, Monday through Friday. 5:30 p.m. to 9:00 p.m., and weekends from 6:45 p.m. to 9:00 p.m. Contact visits are offered weekends, 8:00 a.m. to 6:30 p.m.

For youth placed in Security Risk Group, non-contact visits are permitted Monday through Friday, 8:00 a.m. to 9:00 a.m. and weekends, 4:00 p.m. to 5:00 p.m.

¹³⁶ There are two reports made by the OCA during that time frame.

¹³⁷ Correspondence with MYI administrator, dated Oct. 19, 2017, on file with OCA.

Several years ago, MYI allowed only non-contact visits for the entire population of young adults and youth. Non-contact visits take place with Plexiglas separating the inmate and the visitor while they talk on a phone. Unless there was a special circumstance, no physical contact was allowed between a youth and his parent, caregiver, family member, etc. Over the past several years, the DOC has recognized the importance of contact visits for youth and has changed policies to allow for contact visits when they are earned.

While DOC administration has worked over the years to change policies at MYI so as to permit youth to receive contact visits with family, OCA has repeatedly found that the majority of youth incarcerated in the facility continue to not have contact visits.

Currently, if a youth is not on any Special Administrative Status, he will automatically be allowed contact visits upon admission to MYI. Youth who receive Class A disciplinary reports, such as assault, creating a disturbance, destruction of property, fighting, flagrant disobedience, interfering with safety and security, threats, etc. lose contact visits for 6 months. Youth who receive a Class B disciplinary reports, such as bartering, causing a disruption, contraband, out of place, disobeying a direct order, etc. lose contact visits for 2 months.

During OCA's interviews with the youth, they reported that one of the most meaningful things for them is the ability to have physical contact with someone they care about. Some youth expressed that they would rather not have family members come in to see them if they cannot have contact with them because it is too difficult for the youth and family members.

OCA looked at the history of visitation records (typically only a family member may visit) for **53** youth who were confined at MYI at a point in time in July, 2017. OCA was provided data by MYI with the number of visits the youth had received during the review period. Of the **53** boys whose visit records were reviewed, **25/53** were admitted to MYI prior to 2017; **28/53** were admitted to MYI during 2017; **33/53** youth were sentenced as of July, 2017.

OCA found the following:

- **24/53** youth received **no** visits since their admission to MYI;
- **14/53** youth received **2** or fewer visits since their admission;
- **15/53** youth received more than **2** visits since their admission, with a range of **3** to **42** visits;
- Only **13** of the **53** youth received "contact" visits—meaning that they could touch the family member visiting them.

MYI reported that some youths weren't allowed contact visits due to receiving a disciplinary ticket, being designated as SRG, or being in High Security; while others had visitors at night when contact visits are not allowed.

During the OCA's 2016 review of conditions for youth at MYI, previously reported to the JJPOC, OCA also found that the vast majority of incarcerated youth were not permitted contact visits.

Family Contact and Family Engagement/MYI

MYI does not provide family therapy. The staff who work with the youth can sometimes assist them with contacting a family member if the youth has no money to use the phone. This can be done with the unit counselors twice a month or with the unit captain.

At times, the facility, clinical or educational staff may be able to facilitate contact with a family member if the circumstances warrant such contact; but OCA finds that this is not common practice.

Additional MYI policies regarding visitation are excerpted below:

Courtesy Visit: Upon admission to the facility an immediate family member will be granted one visit prior to the visitor application being processed and approved. A courtesy visitor shall be authorized to visit for up to 14 days.

Regular Visits: Criteria and Authorization: An inmate who anticipates regular visits shall submit the name and address of each potential visitor to the assigned counselor utilizing the Visiting List. The applications and Inmate Visiting rules are mailed to the prospective visitor, who shall complete and sign the application and mail it back to the facility.

Review: The Unit Administrator shall require verification of the visiting application information and any other information deemed significant. A criminal history and warrant query shall be conducted to verify criminal history information.

Current and Ex-offenders: A current or ex-offender who has been convicted of a crime shall be precluded from routine placement on an inmate's visiting list. However, they may request permission to visit, in writing, through the unit administrator. The Unit Administrator will review the request for: severity and nature of the offense; likelihood of ongoing criminal behaviors and discharge or oversight from the criminal justice system.

A proposed visitor can appeal the denial of a request to be placed on a visiting list. MYI has made efforts to approve visitors for incarcerated youth whenever possible. However, in OCA's experience, the facility procedures can be a barrier for some of the youth who may be overwhelmed and not understand how the process works.

Youth access to the unit phone is also a complicated process at MYI. Youth are assigned a PIN number within the first few days of incarceration. In order for them to use the phone, someone from the outside must put money on their account.

YCI

Unlike boys and girls in juvenile facilities, youth in the DOC don't have free access to the phone even for calls to family members. Phone calls can only be made during recreation time. Recreation time is also shower time and large muscle movement time. While the facility has tried to increase this time to 2 hours an evening, in the past it was only for 1 hour and many of the youth only had time to use the shower and phone.

Family Therapy at YCI

According to facility administrators, family therapy is not routinely provided for youth at YCI. However, all incarcerated female youth engage in weekly supportive counseling with the unit social

worker and some work with doctoral psychology students weekly as well. Of the 6 female youth who were admitted between July 1, 2016, and June 30, 2017, **2** had family therapy sessions over the phone on 2 occasions. During OCA's review, another youth began family engagement with her father, facilitated by the unit social worker.

Family Visitation/Contact at YCI

YCI has a large area where multiple youth can have contact visits with visitors and a small area that allows for children to play and interact with mothers or family during visits.

Visiting hours are Monday through Friday, 8:00 a.m. to 10:45 a.m., 1:00 p.m. to 2:15 p.m., and 6:15 p.m. to 9:00 p.m. Weekend hours are the same as weekdays but youth can only receive visits on one weekend day.

Professional visits also occur in the visitation area, with separate rooms where inmates can meet with their attorneys or other professionals from the outside the facility, when approved.

Unlike MYI, almost all of the visits at YCI are contact visits.

Data Regarding Visits with Youth Offenders at YCI

For the 6 youth who were admitted to YCI from July 1, 2016, to June 30, 2017:

- Youth 1 was there for 26 days and had **no** visits.
- Youth 2 was admitted 8/16 and had **29** visits through June 30, 2017.
- Youth 3 was admitted in 8/16 and had **60** visits through June 30, 2017.
- Youth 4 was there for **53** days with **no** visits.
- Youth 5 was there for **57** days with **no** visits.
- Youth 6 was there for **2** days with **1** visit.

OCA FINDINGS - DEPARTMENT OF CORRECTION: MYI AND YCI

Overall, OCA found the experiences of male youth at MYI and female youth at YCI to be very different in all of the areas described above.

SUICIDAL BEHAVIOR AND SUICIDE PREVENTION:

1. While many youth admitted to MYI have documented histories of suicidal ideation/behavior, MYI reported to OCA that there were **0** incidents of suicidal or self-harming behaviors by youth during the PUR.
2. Records reviewed by OCA revealed approximately **two dozen youth admitted** to the MYI infirmary for mental health reasons during the PUR including paranoia, hopelessness, and threatening to self-harm.
3. The DOC's YCI reported **2 incidents** of suicidal or self-harming behavior by two different youth during the PUR (there were 6 girls confined at the facility during the PUR).

4. DOC's facilities did not provide OCA with information regarding participation in an auditing framework for assessing the quality or efficacy of suicide prevention/response protocols.
5. DOC data and UConn Correctional Managed Health Care data regarding the number of youth admitted to MYI and who were subsequently screened for mental health and suicidality do not match. While DOC acknowledged that there are discrepancies with its reporting, it was unable to explain the reasons for those discrepancies.

USE OF FORCE AND ISOLATION-RESTRAINT, SECLUSION AND RESTRICTIVE HOUSING:

6. MYI was not able to provide reliable data regarding use of restraint (physical, mechanical, or chemical) or seclusion during the PUR. YCI reported that no girls experienced physical or chemical restraint during the PUR. DOC has committed to improving their data collection.
7. MYI relies on months-long isolation, sometimes solitary, of minors as part of its Security Risk Group protocols (SRG), where a determination has been made that a youth cannot be safely managed alongside other youth due to the youth's active gang affiliation. During the PUR, youth on SRG status were confined in a Restrictive Housing Unit and were in their cells 21 to 22 hours per day with limited access to education, and no access to rehabilitative programming. Youth on SRG may be handcuffed any time they are not in their cells, including for escort to showers, during large muscle movement, and phone calls. While the DOC asserted the effectiveness of its SRG program for reducing gang-related violence, the agency did not provide OCA with supporting data.
8. OCA finds that the SRG program and its reliance on prolonged physical isolation of minors constitutes "administrative segregation" and as such violates Conn. Gen. Stat. § 18-96b, which statute strictly prohibits the administrative segregation of minors and which was intended to prohibit solitary confinement of minors. The DOC disagrees with OCA's characterization of its SRG program as "solitary confinement" or "administrative segregation," terms often used interchangeably in correctional literature/research nationwide.
9. MYI utilizes routine cell confinement of youth in general population for administrative and security purposes, with youth confined to their cells multiple hours per day in between meals and programming.
10. MYI utilizes shorter term physical isolation (1 to 30 days per instance during the PUR) of minors as a behavioral consequence. Cell confinement is nearly total (23.5 hours per day) and youth on this status have no access to school or rehabilitative programming. **All youth on this status are handcuffed any time they are permitted to leave the cell for hygiene or phone calls.**
11. No youth in isolation (short term or long term) at MYI had an individualized behavior plan to support return to the general population. OCA encountered multiple youth who while in isolation presented as lethargic and depressed, some refusing to engage in basic hygiene activities.

12. DOC policies permit use of chemical agents on youth. OCA found multiple examples of youth with asthma diagnoses who were the subject of chemical agent restraint at MYI. Many states have banned use of chemical agent on minors, and the U.S. Department of Justice has warned that use of chemical spray on juveniles may violate their rights, including the use of chemical agent on youth with respiratory conditions such as asthma.¹³⁸ The DOC's policy requires a review of the youth's medical and mental health history prior to the use of a chemical agent. However, the DOC acknowledged that chemical agents are often used to "quell spontaneous situations that threaten the safety and security of staff, inmates and the public," in which case it would be improbable that such medical review would take place under those circumstances.

ACCESS TO MENTAL HEALTH TREATMENT:

13. DOC leadership states that it "strongly believes that mental health services and non-academic programming at MYI and York meet the needs of the population." However, the DOC "assumed direct responsibility for inmate health care effective July 1, 2018" due, in part, to mounting concerns expressed by the legislature, civil rights groups, and family and friends of inmates about the poor quality of care provided to inmates, resulting in a legislative hearing held in July of 2018. In a September 2018 audit of the DOC, the Auditors of Public Accounts expressed its concern over the health care provided to inmates: "[v]agueness in contract terms, a general absence of measurable performance standards, the absence of recognized standards of care, and the lack of an effective quality control system, impair DOC's capability to ensure proper performance of service by UCHC/CMHC and expose the department to the risk of liability for failure to provide quality care." The OCA commends the DOC for recognizing the deficiencies in its provision of health care services and committing to improving this vital service delivery.
14. DOC facilities reported their policy is to screen all youth for mental health treatment needs and suicidality upon admission.
15. DOC offers mental health treatment services in accordance with a youth's assigned Mental Health Score (1-5). Despite the national data regarding the prevalence of mental health disorders among incarcerated youth and the number of boys at MYI with current or historical mental health diagnoses, the majority of incarcerated boys were assessed by the DOC as either having no history of mental health treatment or not presenting with any current clinical needs. Only 4 boys confined at MYI in July, 2017, for whom Mental Health Scores were provided to OCA, were identified as in need of weekly mental health counseling. DOC asserts that its services meet the needs of the population.
16. OCA examined rehabilitative program participation for 53 boys at MYI confined during the PUR, examining each youth's record of participation for not only the PUR, but the previous 24 months as well, beginning with most boys' date of admission. OCA found that, with an average period of confinement for the 53 youth of 18.6 months, more than half of the boys participated in zero or one program while incarcerated.

¹³⁸ https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/la_county_juvenile_findlet.pdf

17. The DOC acknowledges its problem with data reporting and asserts that “[m]any of the inmates who were reported as not participating in rehabilitative programming, in fact were participating.” DOC stated it is going to remedy its data collection and reporting processes.
18. Girls at YCI were all designated a MH 3 or higher and all of the girls (6 during the PUR) were offered individual counseling from a clinical social worker, one session every week or every two weeks. Participation of girls in group programming varied considerably. All girls are assigned a mentor while incarcerated. Due to the small number of girls, programming can change depending on the population.

ACCESS TO EDUCATIONAL PROGRAMMING:

19. MYI’s U.S.D 1 is the school district run by DOC for youth in its facilities. MYI reports that youth receive 5 hours of school programming a day. OCA found discrepancies in MYI’s attendance and discipline data, including data reported to the State Department of Education, and OCA’s review of the school attendance records for 21 youth at MYI revealed that most youth missed a **substantial** amount of school during the school year. Documented reasons offered for student absenteeism at MYI were variable and include “teacher absence,” “absence (generic),” “custody,” and “class not scheduled.”
20. Similar to the school districts serving youth in detention, USD 1 reported no suspensions of students from the MYI School, which is likely due to the fact that when a youth has a behavioral incident in school, custody staff are called and facilitate the school removal. However, any school removal for behavior is governed by state suspension laws. This review revealed that the USD 1 staff are not following state and federal special education laws regarding cumulative school removals. The DOC disagrees with OCA’s finding based on its opinion that the school suspension statute “makes no sense in the context of the Department of Correction,” and that “it is not school staff who is removing inmates from the school – it is custody staff. The school is not effectuating or controlling the removals, or the length of the removals. Special education laws regarding cumulative school removals, therefore, do not apply.”
21. MYI has limited resources to provide comprehensive special education and related service delivery to eligible youth, and few youth receive vocational programming. The DOC reports 14 of 109 students at MYI participated in vocational classes during the PUR.
22. OCA’s record review revealed that USD 1, revised the special education plans of youth entering the facility to decrease the hours and services previously identified in their Individual Education Plans (IEP).
23. Youth in Security Risk Group experienced the most dramatic limitation to access to education. IEPs of youth in SRG were found to have been modified to reflect significant reduction in education/special education services. Youth in shorter term isolation for disciplinary reasons were found to not receive tutoring or go to school, but youth may have received a packet of educational work sheets.

24. YCI reported 2 girls under the age of 18 began school on September 6, 2016. YCI reported no suspensions or removals from programming. During the PUR, both girls were absent approximately 10% for the following reasons: Court, Legal or Facility Security.

ABUSE/NEGLECT AND MANDATED REPORTING:

25. DOC correctional staff and facility administrators are not identified as mandated reporters in state law. The only DOC staff members who are mandated to report suspected abuse or neglect are those whose professional credentials identify them as such, e.g., a medical professional, clinician, or teacher working in the facility. DOC reported to OCA that it had made two reports to DCF during the PUR. OCA's review of the DCF database revealed no documented reports of suspected maltreatment made to the DCF Careline by anyone at DOC/CMHC during the PUR.
26. DCF has an imbedded staff at DOC-no reports of suspected abuse or neglect were made by the DCF staff on site in the prison.
27. There is no framework for training DOC employees at MYI or YCI on abuse/neglect reporting.
28. There is no agency or independent ombudsman for youth incarcerated in DOC facilities.

FAMILY CONTACT/FAMILY ENGAGEMENT:

29. Almost half of boys incarcerated at MYI had no visits during the review period, and only 13 boys were permitted "contact" visits where they are allowed to touch a family member.
30. MYI does not offer family therapy.
31. MYI offers visitation hours to families in the evening throughout the week and during the day and evening on weekends. Contact visits (where a boy and his family member can physically touch) are only offered on weekends. For boys in Security Risk Group, non-contact visitation is only offered on two one-hour sessions during the week, and most boys on SRG had no visits during the PUR.
32. OCA's examination of visitation records for a sample of 53 youth at MYI showed that 45% of boys had no visits during their admission, and an additional 15% of youth had 2 or fewer visits. Only 13 of the 53 youth were permitted "contact" visits. Contact visit privileges are suspended or terminated due to disciplinary tickets. Contact visits are also not allowed at night. Boys reported to OCA that visits are one of the things that mean the most to them, but that some would rather not have a family come to see them if they cannot have contact with them because it is too difficult of an experience.
33. Youth are not permitted free phone calls at MYI, unlike youth in juvenile justice facilities.

34. Visitation resources differ at YCI as compared to MYI, and all youth are permitted contact visits with family.
35. YCI does not routinely provide family therapy for female youth, but family therapy may be facilitated by the unit social worker. During the PUR, two youth had family therapy sessions over the phone on two occasions. All of the youth are entitled to contact visits. YCI has a large general visitation area and a small area that permits children to interact with mothers or family members during visits. OCA's review of visitation data revealed that of the 6 girls incarcerated during the PUR, 4 youth had 1 or no visits (with an average length of confinement of 34 days at the time of review.) Two girls had more than two dozen visits, and both girls had been confined for approximately 10 months.

AGENCY RESPONSE: DOC

Leadership of the Department of Correction has reported that it remains committed to working with stakeholders seeking to improve outcomes and conditions of confinement for youth. Leadership responded to OCA findings that agency policies and practices are consistent with best practice for adult correctional programs and while they have made some effort to adapt practice for the state's youngest offenders, they believe youth would be better served **outside of an adult correction system**. DOC further responded that these youngest offenders frequently present with the most challenging behaviors and restrictive measures utilized are needed to ensure staff safety and facility security. DOC does not agree with the OCA finding that its use of isolation for behavior management constitutes solitary confinement. DOC acknowledged limited staffing resources and flexibility. MYI's physical plant is structurally incompatible with implementing age/developmentally appropriate programming. DOC indicated that it intends to seek consultation with national experts with whom it has been working to develop effective programs for incarcerated young adults.

DEPARTMENT OF CHILDREN AND FAMILIES - CONNECTICUT JUVENILE TRAINING SCHOOL

The Connecticut Juvenile Training School closed in April of 2018 and responsibility for youth adjudicated were no longer committed to the custody of DCF, but to supervision of the Judicial Branch effective July 1, 2018. In July of 2015, the OCA published a comprehensive investigative report into the care and treatment of youth at CJTS.¹³⁹ As OCA's review was conducted while CJTS was still operating, and for the value of comparing relevant conditions of confinement for youth across state agencies, this report will still include pertinent information obtained regarding conditions for youth confined at CJTS through 2017. Some of the information discussed in this report regarding CJTS is briefer than information discussed regarding conditions for youth in CSSD detention facilities or DOC prisons due to the winding down and eventual closure of CJTS during the development of this report.

¹³⁹ https://www.ct.gov/oca/lib/oca/oca_investigative_cjts_pueblo_report_july_22_2015.pdf
<https://www.ct.gov/oca/lib/oca/investigative072215.pdf>

During the PUR, CJTS administration reported that the facility had adopted a restorative philosophy which they described as “a way of viewing justice that puts the emphasis on repairing harm caused by conflict and crime. In this approach crime is understood as a violation of people and relationships and a disruption of the peace of the community. It is not simply an offence against the state. Restorative justice is collaborative and inclusive. It involves the participation of victims, offenders and the community affected by the crime in finding solutions that seek to repair harm and promote harmony”. (CJTS description on file with OCA) ?NEEDS FOOTNOTE

During the PUR (July 1, 2016 – June 30, 2017):

- There were **113** admissions to CJTS (**58** of which were re-admissions). The average expected length of incarceration at CJTS was **6** months.
- Discharges from CJTS: **109** youth were discharged from CJTS -- **27** were discharged to congregate care; **79** youth were discharged home; and **3** youth were remanded to the DOC.¹⁴⁰

A. SUICIDAL BEHAVIOR/SUICIDE PREVENTION

In response to the requests for information from the OCA, administrators from CJTS reported that there were **0 incidents of suicidal or self-harming behaviors**¹⁴¹ by youth during the 12 month PUR.¹⁴²

Given the number of youth confined in CSSD facilities during the PUR who were assessed as being at risk of or actively engaging in suicidal behavior or ideation, OCA reviewed a sample of records¹⁴³ related to youth confined at CJTS during the PUR, which sample indicated that there were multiple youth who staff documented as having engaged in self-harming behavior, including with a stated intent to die.

Notes below are drawn from CJTS facility records.

- Youth One 7/6/16
Placed on Safety Watch after cutting left forearm while in the padded cell and smearing blood on the walls.
- Youth One 7/10/16
Youth has been highly dysregulated in his mood and behavior, including multiple episodes of self-harming threats and behavior (e.g., scratching arms and tying shirts around his neck) and

¹⁴⁰ Race admission data for **89** youth at CJTS from January 1, 2017 through June 30, 2017 during a six month period of review: **41** African American/Black; **32** Hispanic; **11** White/Caucasian; **1** Asian; the remaining **4** listed as Other.

¹⁴¹ OCA supplemented its original information request and sought data regarding any incident of self-harming/injurious behavior during the PUR.

¹⁴² Correspondence between OCA and CJTS administrators clarified that administrators defined suicidal ideation as any “statement of suicide with or without a plan.” In the same correspondence CJTS confirmed that no youth engaged in any self-injurious behavior during the PUR (7/1/2016 through 6/30/2017).

¹⁴³ OCA reviewed case records associated with youth that came to the attention of OCA as having potentially significant unmet treatment needs.

has warranted multiple physical interventions and seclusions. These behaviors appear to be subsequent to increased anxiety.

- Youth Two 7/29/16
Youth was in room and had a nose bleed. Moderate amount of blood on bed, sheet, towel and pillow. Youth said he tied his shirt around his neck and when he released it his nose bled. Youth met with clinician after he wrapped his sweatshirt around his neck. He was crying and repeatedly stated he couldn't do this, he gives up. Reported strongly wanting to die due to being in this facility and due to an assault in detention.
- Youth Three 12/5/16
Youth placed on safety watch after making several vague suicidal statements and tying a sheet around his neck. He was also able to access several metal pieces that he refused to give up, and took back his shoelaces, threatening that he "wouldn't be alive tomorrow."
- Youth Four 12/17/16
Resident placed in padded cell. Banging his head and wrapping his shirt around his neck. Was able to calm down and was seen by nurse. Returned to the unit and placed on "No Access."¹⁴⁴

Screening at CJTS

CJTS administrators provided information regarding the facility's methodology for screening youth for suicide risk factors. The facility reported that since September 2015 the clinical department began using the Suicide Assessment Five-Step Evaluation and Triage for screening purposes. In January 2017 the facility implemented the Columbia-Suicide Severity Rating Scale Lifetime Recent and Screen version. All youth were reportedly screened for suicidal ideation and related risk and protective factors as part of the admission assessment, and the results were reviewed and updated as part of the 14 day assessment and 30 day clinical evaluation for youth subsequent to admission.

¹⁴⁴ "No access" is a facility term for cell confinement/seclusion.

Monitoring of Youth at CJTS

CJTS reported that there were **37** youth assessed for their safety during the PUR, with **15** youth placed on a safety watch as a result. The facility safety watches include direct observation (initiated by custody staff pending clinical assessment), 10 minute safety watch (initiated through clinical assessment), 5 minute safety watch (also initiated through clinical assessment) and 1:1 safety watch as the most intensive monitoring for youth assessed at significant risk for suicide. Per CJTS administrators, no youth voiced a plan or an intent to die. Two of the youth made a suicidal gesture by placing an item around their neck but quickly removed the item independently and denied that their intent was to kill themselves.

CJTS reported that of the **15** youth placed on safety watch:

- **9** youth were placed on a 10 minute general safety watch for support.
- **4** youth were placed on 1:1 status.
- **3** out of the 15 youth were placed on more than one safety watch during the time period.

Research has shown that suicidal ideation is higher in post-adjudication youth than in pre-adjudication youth, with some studies showing that suicidal ideation for post-adjudication youth in secure facilities was 51% (past year) and 58% (life time).

Most studies have found that girls have higher rates of suicide attempts than boys.

Source: Teplin, L., Stokes, M., et al., *Suicidal Ideation and Behavior in Youth in the Juvenile Justice System: A Review of the Literature*, Jour. Correct. Health Care (July 2015).

Quality Assurance for Suicide Prevention

CJTS provided OCA with their facility suicide assessment and prevention policy. The policy did not specify quality assurance activities used to evaluate the efficacy of its suicide prevention policies, the safety of the physical plant, or the adherence of its staff to suicide prevention protocols and communication requirements.

OCA is aware that a March 2016 suicide prevention audit was commissioned by DCF and performed by UConn Correctional Managed Health Care. This audit took place subsequent to the OCA's 2015 investigative report, which was critical of treatment planning, crisis management, and suicide prevention efforts at CJTS and Pueblo. The 2016 audit identified the need for numerous changes and modifications to policy, programming and the structure of both secure facilities. The auditors made 19 programmatic recommendations and 71 recommendations for modifications to the CJTS facility. Major recommendations included:

- Improvements to safety watch protocols, clinical follow-up, monitoring, and documentation.
- Development of a quality assurance and continuous quality improvement program for suicide prevention.
- Modifications to ceiling vents and sprinklers where youth can attach or affix ligatures for self-strangulation.
- Efforts to minimize and eliminate blind spots in facility cells.
- Modification of bathrooms to reduce opportunity for self-injury.

In May and June 2016, OCA and the Office of the Chief Public Defender's Post-Conviction Unit wrote to DCF administrators seeking information regarding necessary improvements to suicide prevention protocols and facility practices for responding to high-risk youth. DCF responded with details about its action steps to address various recommendations from the UConn auditors. In

December 2015, Governor Malloy announced the intended closure of CJTS and subsequent to that announcement the number of youth confined at CJTS steadily declined, with the facility ending admissions in January 2018. Per DCF administration, no further external suicide prevention audits were conducted, anticipating closure.

B. USE OF FORCE AND ISOLATION – RESTRAINT, SECLUSION AND RESTRICTIVE HOUSING

As previously stated, CJTS was governed by the state’s “person at risk” statute which prohibits any non-emergency use of restraint or seclusion. OCA’s 2015 investigative report regarding conditions of confinement at CJTS and the Pueblo girls’ secure facility found that both interventions were used inappropriately and in a manner inconsistent with state law.

Restraint -- CJTS policy provides that restraint may only be used as a response to “emergency situations and after all less restrictive strategies have been exhausted.”

Seclusion -- CJTS policy defines seclusion as “maintaining a resident in a room, whether alone or with staff supervision, utilizing a door that is locked, except that the term does not include the placing of a youth in a secure room for the purpose of sleeping.”

Mechanical restraint -- “may be used if there is a reasonable cause to believe that the resident may inflict physical injury on himself or others and as a precaution against escape.”

Documentation and Review -- Facility policy also requires that staff use video cameras when utilizing restraint during an incident, that clinical and medical staff assist in assessment of youth during or after restraint incidents, that all staff participating in an emergency intervention submit required documentation, and that staff receive a debriefing from supervisory personnel after incidents take place.

N

Data

For purposes of this review, CJTS reported the following restraint data for the six-month PUR¹⁴⁵:

- **164** physical restraints of youth for reasons such as fights with peers, peer conflict, milieu disruption, school disruption, and property destruction.
- **34** mechanical restraints for “safety transportation.”

CJTS reported the following seclusion data for the PUR:

- **60** instances of seclusion for greater than 4 hours.
- **28** instances of seclusion for greater than 8 hours.

OCA Data Review- OCA reviewers examined the seclusion/room confinement data in the CJTS CONDOIT system in conjunction with the individual case files of those youth who were identified as being placed in seclusions/room confinement for the period January 1, 2017-June 30, 2107. The

¹⁴⁵ OCA did not review youth specific data regarding restraint.

numbers reported by CJTS administration in response to the OCA's review, which numbers are also provided on a monthly basis to the CJTS Advisory Board were significantly lower than those recorded in CONDOIT. The review found multiple incidents where youth were secluded, which were not accurately documented or reported by CJTS administration.

For example, CJTS reported that during January 2017, there were 13 instances of youth placed in seclusion/room confinement for greater than 4 hours; while OCA's review of CONDOIT and individual case files found over 25 instances of seclusion/room confinement greater than 4 hours.

During February 2017, CJTS reported 7 instances of youth being placed in seclusion for greater than 4 hours, and **no** incidents of seclusion that lasted longer than 8 hours. OCA's review of CONDOIT and individual case files found 9 instances of seclusion greater than 4 hours, and 3 instances of seclusion greater than 8 hours.

CJTS administration was not able to explain these discrepancies.

CJTS policies regarding restraint and seclusion are entitled "Safe Crisis Intervention." OCA's review of youth-specific records **and** DCF internal investigation documents reveal that the facility policies regarding use of force were not consistently followed. Multiple internal investigations conducted by DCF into allegations of suspected abuse or neglect of youth in the facility documented concerns about the failure to follow facility/agency policy regarding the use of video recording of incidents and the responsibility of management to adequately de-brief with staff after incidents of restraint.

C. ACCESS TO MENTAL HEALTH TREATMENT

According to information provided by the CJTS administration to the OCA, the Clinical Department maintained 24 hour coverage, (on site and on-call) 365 days per year. Hours were typically 8:30 a.m. to 5 p.m. (information provided did not specify whether this was 5 days or 7 days per week). Clinical staff offices are located within the housing units.

From January 1, 2017, to June 30, 2017, there were 6 active clinicians, including licensed clinical social workers and licensed clinical psychologists. During this time there were an average of **50** boys confined at CJTS per month. Accordingly, the average clinician-to-client ratio was 1 to 8.3.

Assessment/Evaluation

CJTS reported that the Clinical Department completed an integrated assessment for youth admitted to CJTS to identify and evaluate each youth's need for clinical services. The integrated assessment included an interview of the youth by the primary clinician assigned to the case and a psychiatrist, a review of records, and a parent interview. At the 30-day mark, the integrated assessment was presented at a Plan of Service meeting with clinical recommendations.

Access to Treatment Services

CJTS reported that the Clinical Department offered a wide array of mental health services including individual and family therapies, group therapies, assessment, treatment planning, crisis intervention,

psychiatric evaluation, and medication management. Core programming at CJTS included the following:

Seven Challenges: An evidence-based substance abuse program provided to incarcerated youth with substance abuse disorders. The program teaches decision making through seven prescribed challenges during the treatment process

Power Source: An evidence-based, trauma-informed social and emotional learning program offered to all incarcerated youth.

The Clinical Department contracted with community providers to offer services for problem sexual behavior, intimate partner violence, domestic violence, and other specialized services.

CJTS administrators did not provide documentation or data regarding utilization or completion rates for these services.

Utilization of mental health services at CJTS

CJTS provided OCA with a chart of all the boys who were incarcerated in the facility during the PUR. CJTS reported that the average rate of clinical contact per youth was **1.3** contacts per day and emphasized the significance of having clinical staff embedded in each housing-with opportunities for informal (and possibly undocumented) interaction. Formal documented individual sessions by clinicians were reported to be held minimally 1x/week. CJTS administration indicated that it defines a “clinical contact” as “any face to face with the youth.”¹⁴⁶

Given that the high rate of clinical contact reported by the facility did not coincide with information previously reviewed by OCA, OCA again reviewed all documentation on clinical services provided to a sample of **15** youth confined at CJTS during the PUR. The youth whose records were examined were known to OCA as having extensive clinical and behavioral health treatment needs and would therefore be likely to require frequent clinical contact and intervention. OCA examined all documented individual clinical contacts including any face-to-face between each youth and his clinician, any individual therapeutic sessions, and all participation in therapeutic group programming.

OCA’s review of youth-specific records found the following:

1. The average length of incarceration for the **15** youth was **6** months (ranging from 2 months to 11 months)
2. **None** of the records reflected at least daily clinical contact (face-to-face).
3. The frequency of documented clinical sessions per youth varied greatly. The average # of individual session contacts per youth was **3.7** per month.
4. The range of individual clinical session contact per youth was **1** to **9** sessions per month.
5. Average # of group therapy contacts per youth was **3.9** sessions per month.
6. The range of group therapy utilization per youth was **0** to **13** sessions per month.

D. ACCESS TO EDUCATIONAL PROGRAMMING

CJTS administration provided educational information as follows:

¹⁴⁶ Email from CJTS Superintendent to OCA staff, Sept 11, 2017, on file with OCA.

103 students were identified as being served by at CJTS during the 12 month PUR. As of October 1, 2016 the CJTS school district (USD-II, the district responsible for students at CJTS and the DCF-run Albert J. Solnit Psychiatric Center) reported to the CSDE that it was serving **41** boys. **27/41** students were identified as eligible for special education services.

CJTS did not provide attendance data generally, but it did provide the facility's record of disciplinary reports for the 103 students. USDII did not provide absenteeism data to the state in its school profile and performance report for 2016-17, citing the need to suppress data to ensure student confidentiality.

- **40** of the students received at least one school suspension, including in-school and out-of-school suspension.
 - **23** students received an in-school suspension.
 - **17** students received an out-of-school suspension.
- **10** students received more than 1 school suspension.
- Over **70 %** of the students were removed from class on one or more occasions.

CJTS did not provide OCA with information regarding its special education identification and referral protocols.

E. ABUSE/NEGLECT AND MANDATED REPORTING

Between January 1, 2015, and October 4, 2017, there were **45** accepted reports of suspected abuse or neglect of children confined at CJTS. All of the reports were investigated internally by DCF's Special Investigations Unit (SIU). **7** of the **45** reports resulted in substantiated findings of child abuse or neglect. Allegations contained in reports to DCF included physical and emotional neglect and physical abuse.

Several investigations led DCF's internal investigations unit to identify "program concerns" at its facility, including deficiencies in the manner in which staff adhered (or failed to adhere) to the facility's policies and procedures for interacting with children. Identified program concerns documented on multiple occasions by SIU include:

1. Failure to follow protocols for use of force.
2. Failure to document incidents adequately, including use of force and youths' self-harming behavior.
3. Failure to adhere to agency policy regarding the use of hand-held cameras to record incidents and staff use of force.
4. Failure by management to de-brief with staff after incidents involving physical restraint.

All CJTS staff were trained on mandated reporter obligations. Reports were most often called into the DCF Careline by facility managers, administrators, clinical staff, or the DCF Ombudsman. Reports were also called in by the OCA and the Public Defender's Office. Prior to and following release of OCA's investigative report in July, 2015, regarding conditions at CJTS, DCF instituted internal changes to ensure proper acceptance of reports of suspected abuse and neglect of children incarcerated at CJTS. Thereafter, the contents of investigative reports improved, with a more comprehensive focus on facility policies and staff conduct.

OCA also finds that the role of the facility Ombudsman is critical to ensuring that youth are heard regarding conditions of confinement. The DCF Ombudsman regularly shared information regarding youth grievances with OCA and public defenders and periodically made reports to the DCF Careline regarding concerns of abuse and neglect.

An ombudsman can play an important role in assessing and reporting concerns that constitute 1) a possible violation of law; 2) a possible violation of facility/agency policy; or 3) an action/incident inconsistent with best

F. ACCESS TO FAMILY CONTACT/FAMILY THERAPY

CJTS administrators provided the following information:

- Family therapy was available to all boys at CJTS. However, family therapy was dependent on a number of key factors- a youth's willingness to engage, his family's willingness to engage, his age (may be 18 years old), availability of family resources, dual commitment status with no family resources, residence of the parents (may be out of state), etc.
- Visiting hours are offered Saturday, Sunday and holidays from 11:30 a.m. to 5:00 p.m. In addition, weekday visiting hours are offered on Tuesday, Wednesday and Thursday from 6:00 p.m. to 8:00 p.m.
- Total number of boys at CJTS during the PUR: **89**
- Family Sessions - **165** occasions for all incarcerated youth.¹⁴⁷
- Visitation data--
 - On average, the frequency of family visits per youth per month was **1.8**.
 - **68** boys (76%) had at least one family visit during the PUR.
 - **21** boys (24%) did not have a family visit during the PUR.

OCA broke down the visit information by youth.

- **34/89** boys had 1 or 0 visits during the six-month PUR.
- **31/89** youth averaged at least 1 visit per month during the PUR with a range of 6 visits in 6 months to over 20 visits in 6 months.

Number of Visits	Number of Youth
0 visit	21 youth
1 visit	13 youth
2 visits	8 youth
3 visits	4 youth
4 visits	6 youth
5 visits	6 youth
6 visits	6 youth
7 visits	5 youth

¹⁴⁷ CJTS administrators reported that clinicians attempt to speak to family members by telephone as well and they provided data that there were 682 such calls during the PUR, which would average 1.5 calls to family per incarcerated youth each month.

8 visits	2 youth
9 visits	3 youth
10+ visits	9 youth
20+ visits	6 youth

Given that CJTS was a longer-term secure facility with an emphasis on rehabilitation (rather than custody prior to trial), OCA examined discharge outcomes for boys from CJTS during the PUR and compared discharge data to family therapy data. OCA found that most of the boys discharged home had few or no family therapy sessions prior to discharge.

- **46/89** boys incarcerated during the PUR were discharged home during that timeframe.
- More than half of the 46 boys discharged home (**26/46**) had **1** or **0** family therapy sessions during the PUR.
- The majority of boys (**38/46**) had **3** or fewer sessions during the PUR.¹⁴⁸

OCA FINDINGS - CJTS

SUICIDAL BEHAVIOR/SUICIDE PREVENTION:

1. While many youth admitted to CJTS have documented histories of suicidal ideation/behavior, CJTS reported to OCA that there **were 0 incidents of suicidal or self-harming behaviors by youth** during the PUR. OCA's review of youth-specific records however, revealed multiple incidents of youth expressing suicidal thoughts or engaging in self-harming behavior.
2. During a previous review of conditions of confinement at CJTS from 2014 to 2015, OCA found more than 4 dozen incidents of suicidal or self-harming behavior.¹⁴⁹
3. CJTS did not provide OCA with information regarding participation in an auditing framework for assessing the quality or efficacy of suicide prevention/response protocols.

USE OF FORCE AND ISOLATION-RESTRAINT, SECLUSION AND RESTRICTIVE HOUSING:

1. OCA's review found significant discrepancies in reported data regarding the use of restrictive measures.
2. OCA's review found multiple examples that CJTS staff used cell/room confinement (physical isolation) as a disciplinary sanction.

¹⁴⁸ This data refers to in-person family therapy sessions.

- 13 youth had no family therapy.
- 13 youth had 1 family therapy session.
- 12 youth had 2 or 3 family therapy sessions.
- 6 youth had 4-8 family therapy sessions.
- 2 youth had 10 or more family therapy sessions

¹⁴⁹ OCA Report: Investigative Facility Report Connecticut Juvenile Training School and Pueblo Unit, and Addendum, available on the OCA website:

https://www.ct.gov/oca/lib/oca/oca_investigative_cjts_pueblo_report_july_22_2015.pdf;

https://www.ct.gov/oca/lib/oca/ocaaddendumfinal_9_1_5.pdf

3. CJTS reported that between 30-40% of youth were subject to a restraint during the PUR.

ACCESS TO MENTAL HEALTH TREATMENT:

1. CJTS had an expected length of confinement of 6 months. Youth were screened for mental health treatment needs and suicidality upon admission, and clinical staff developed treatment plans and goals for all youth.
2. OCA's review of youth specific records indicated that even youth with complex mental health treatment needs received, on average, out-patient level of care (3.7 sessions per month), utilization of individualized and group programming by youth varied considerably, and some youth participated in few or no group programs during the review period.

ACCESS TO EDUCATIONAL PROGRAMMING:

1. CJTS's school is run by U.S.D. 2, the school district administered by DCF for youth in DCF-run facilities. CJTS provided information that for the 103 students in the CJTS School during the PUR, 40 students received at least one suspension, and 10% were suspended on multiple occasions.
2. More than 60% of youth at CJTS were identified as eligible for/receiving special education services.

ABUSE/NEGLECT AND MANDATED REPORTING:

1. All DCF employees at CJTS are mandated reporters and receive training regarding reporting obligations.
2. Over a 34 month period (through 2018) there were 45 reports to DCF of suspected abuse or neglect of children at CJTS. These reports, like any facility report of abuse or neglect, are investigated by DCF's internal Special Investigations Unit (SIU). 7 of the 45 reports were substantiated by DCF as child abuse or neglect. Several investigations led SIU to identify program concerns at CJTS, including staff failure to follow protocols for use of force, failure to document incidents adequately or accurately, and failure by management to de-brief with staff after incidents involving physical restraint.
3. The DCF/CJTS ombudsman is a DCF employee. The ombudsman has filed multiple reports of suspected abuse or neglect to DCF during the last three years.

FAMILY CONTACT/FAMILY ENGAGEMENT:

1. Data review for 89 youth who were at CJTS during the PUR showed that **51%** of those youth were discharged home. More than half of the 46 boys discharged home (**26/46**) had **1 or 0**, in-person family therapy sessions during the PUR.
2. Data review showed that while **76%** of all youth had at least one family visit during the PUR, **24%** had no visits.

OCA RECOMMENDATIONS

There is a need for a greater transparency and accountability with regard to conditions for children and youth in congregate care and confined/secure settings. While there is public information regarding conditions and incidents of abuse and neglect in certain types of regulated programs serving vulnerable populations (i.e. daycares and nursing homes), there is little to no published information regarding the safety and quality of youth-serving programs, including group homes, residential treatment facilities, juvenile or criminal justice facilities, whether such facilities are licensed by or run by the state. OCA recommends that a framework be urgently developed for the collection and publication of critical performance and outcome measures expected for secure and non-secure youth-serving facilities, including measures related to concerns of abuse and neglect, program/licensing concerns, and corrective actions.

SUICIDAL BEHAVIOR AND SUICIDE PREVENTION

1. Connecticut should standardize how suicidal and self-harming behavior is collected and reported for youth in confinement.
2. Consistent with expert recommendations, all juvenile-serving correctional facilities should have a “quality assurance process in place to monitor the components of a facility’s suicide prevention program with immediate modification made when indicated.”¹⁵⁰
3. All youth-serving facilities should undergo an annual audit of the facility’s physical environment for suicide resistance.
4. Closed-door cell confinement should be limited for juveniles and prohibited for juveniles who present with risk for potential or actual suicidal behavior. All room checks should be conducted at staggered intervals.
5. Staff must receive evidence-based training in identifying risk factors for suicide among the juvenile population to ensure that vulnerable youth are identified, supported and monitored. Threats of self-harm should never be dismissed as “attention seeking.” According to experts, “there is no way to tell if youth are manipulating or truly want to die; ‘Manipulative’ individuals have died by their own hands. Although frustrating and difficult to manage, youth who engage in suicidal behavior solely to solicit attention, facilitate a transfer, or obtain coveted resources can accidentally kill themselves.”¹⁵¹
6. Staff training should include information regarding the risk to youth created by any transition, including transitions home.
7. Any instance of suicidal behavior should trigger a comprehensive case review with participation from clinical and facility operations staff.
8. Suicide screening should be done not only at intake but on a continuous schedule for all confined youth.

USE OF FORCE AND ISOLATION—RESTRAINT, SECLUSION AND RESTRICTIVE HOUSING

1. Consistent with the recommendations from the Department of Justice, the American Psychiatric Association, the National Commission on Correctional Health Care, and other professional organizations, Connecticut should ban solitary confinement of minors.
2. State law must be revised to clarify what constitutes impermissible solitary confinement, but consistent with most national associations’ definitions, the state should ensure that it prohibits

¹⁵⁰ OJJDP/NIC Guide, *supra*, N. 2, Ch. 11, Boesky, P., “Mental Health.”

¹⁵¹ *Id.* at 18.

isolation practices that confine children to their cells for the vast majority of a 24 hour period without access to meaningful rehabilitative and education services, pro-social interaction and other needed services and interventions.

3. Given the paramount importance of ensuring a safe and secure milieu for juvenile offenders and the staff who work with them, the DOC and, where applicable, CSSD should work with national experts to improve safety outcomes without relying on the physical and social isolation of minors. The agencies should seek technical assistance, as needed, to support the prevention of behavioral incidents that typically lead to harsher discipline or isolation measures and an unsafe environment.
4. Connecticut correctional facilities should follow toolkits developed by the Council of Juvenile Correctional Administrators (CJCA) to assist with reducing isolation of juveniles. CSSD is using these tool kits now and working to reduce reliance on cell confinement as part of its youth in custody practice model.
5. State law should prohibit the use of chemical agents on children/youth by all local and state agencies.
6. State law should prohibit the use of prone restraints with minors across all state and local agencies. State law currently bans prone restraints for students and most state agencies, including DCF and DDS, have banned use of prone restraints due to concerns over airway restriction and other negative physical effects. These critical considerations do not change even if the youth's service or custodial setting changes.
7. Similar to state laws that govern treatment and emergency intervention for youth with disabilities or challenging behaviors, correctional facilities must be required to implement behavior intervention plans for youth whose behavior interferes with the safety of others and limits the youth's participation in rehabilitation activities.
8. The state should standardize statutory definitions and policies regarding the use of force and the use of punitive and restrictive measures for minors, regardless of correctional setting. Today there are conflicting definitions of use of force or isolation applicable to incarcerated youth, and statutes frequently provide no definition at all.
9. Professional agencies meeting with youth in correctional/secure settings should consider the use of screening tools to assist with the discussion of certain conditions of confinement with children. Custodial agencies should provide a mechanism for professional visitors to meet with children on the units where they are confined.
10. All agencies must ensure that they can collect and produce accurate data regarding the use of force and physical isolation on children. Each agency should have a reliable continuous quality improvement plan that addresses the use of emergency and isolation measures.

ACCESS TO MENTAL HEALTH TREATMENT

1. All facilities must ensure they have accurate record-keeping and data collection processes regarding youth's access to and utilization of mental health and rehabilitative programming.
2. All facilities should be required to report regarding youth/family utilization of clinical and rehabilitative programming.
3. All youth facilities should have trauma-responsive rehabilitative, pro-social, and clinical programming embedded into their daily schedule, seven days per week.

4. All youth facilities should be adequately resourced to ensure provision of 7-day per week intensive pro-social, rehabilitative and clinical programming.
5. All facilities must ensure staff are trained in how to maintain a trauma-responsive milieu and how to recognize signs of trauma in youth's behavior.

ACCESS TO EDUCATIONAL PROGRAMMING

1. All facilities must have clear and specific frameworks for ensuring compliance with all state and federal education laws regarding attendance, discipline, special education, and record-keeping.
2. All facilities must be required to report regarding the provision of educational services to incarcerated youth, including data regarding attendance, discipline, special education service delivery (with information regarding availability and utilization of special education and related services).
3. Facilities must ensure effective intake and discharge procedures for educational programming purposes. No youth should be discharged without an educational plan which includes a plan for immediate enrollment in an appropriate program.
4. The State Department of Education should provide guidance to school districts regarding necessary practices to facilitate record-sharing, educational meeting participation, and enrollment for justice-involved youth.

ABUSE/NEGLECT AND MANDATED REPORTING

1. State law should require that all facility staff working with children in confinement and all staff under contract to work with children in confinement be mandated reporters of suspected abuse and neglect.
2. All facilities for incarcerated youth should maintain an independent ombudsman to meet regularly with children, tour the facility, address concerns with administration and outside parties, and make reports of abuse or neglect where applicable. All ombudsmen/women should be mandated reporters of suspected abuse or neglect.
3. All youth-serving facilities must pay close attention to strengthening their frameworks for mandated reporting, not just of suspected abuse or neglect by third party caregivers but by facility staff as well.
4. All employees must be trained to understand that it is not their role to evaluate or investigate allegations of suspected child abuse or neglect, and that their only obligation is to report a "reasonable suspicion." Protocols, training and guidance for staff should acknowledge that suspected abuse or neglect may often need to be reported internally and externally. Agencies must emphasize compliance with legal requirements for reporting to law enforcement and child welfare authorities, while ensuring clear internal reporting protocols for suspected child abuse or neglect and other incidents of child maltreatment. Policies should specify what staff behavior the facility will respond to internally and what behaviors must be reported to authorities.¹⁵²
5. Policies and training regarding staff-youth boundaries should recognize a balance between "encouraging positive and appropriate interactions and discouraging inappropriate and

¹⁵² *Preventing Child Sexual Abuse Within Youth-Serving Organizations, Getting Started on Policies and Procedures*, Center for Disease Control (2007) at 17, report available on the web at: <https://www.cdc.gov/violenceprevention/pdf/preventingchildsexualabuse-a.pdf>.

harmful interactions.”¹⁵³ Not all physical/verbal expressions of support between staff and a youth are inappropriate. A pat on the back or physical expressions of comfort or consultation may be an appropriate response, depending on context, age of youth, and environment.

6. Agencies should ensure human resource policies include specific disciplinary actions for failure to comply with mandated reporting requirements.
7. Agencies should include continuous quality improvement plans for ensuring effective strategies to prevent child maltreatment and encourage compliance with mandated reporting obligations.
8. Sexual abuse prevention training should be required for all facility staff. Training regarding abuse and neglect, including staff sexual abuse of children, must be data-driven, scenario-based and interactive. Recognizing concerns of staff sexual misconduct and responding timely and effectively can be difficult due to what experts identify as the cognitive dissonance barrier that affects staff perception or detection—meaning that most people will disbelieve that anyone they know or work with would sexually mistreat a child. However, statistics regarding sexual abuse of adolescents, self-reported in surveys, strongly suggest that prevalence rates for adult/staff/teacher sexual misconduct with children are much higher than what is reported and investigated. Effective training and preparation of staff to understand the prevalence of such incidents and respond to concerns, even rumor and innuendo, can assist with better prevention and response to concerns of staff sexual misconduct. Agencies must have clear requirements for “reporting suspicious adult behavior, and an effective complaint system including definitions, administrative consultation protocols, investigations and criminal referral processes, parental notification requirements, administrative resolution steps and immunity and retaliation considerations.”¹⁵⁴ Policies must emphasize that suspicion is enough, particularly because most sexual abuse will happen when perpetrators believe they will be undetected and reporters will often not be direct witnesses to sexual misconduct.
9. Staff training must include an understanding of trauma, its impact on youth behavior and the need for gender-specific and responsive programming for incarcerated children, with explicit attention to populations uniquely vulnerable to abuse and neglect, such as children who are LGBTQ-I and those with disabilities.
10. Supervision and training for staff in youth-serving facilities must address policies regarding use of technology, electronic communication, social media, and smart phones.
11. All facilities should have a clear framework for the use of video cameras and the review of video footage to support a safe environment for children and staff and enhance quality assurance activities.
12. All facilities should have a data-driven approach to risk management, including identifying the most common factors in incidents of concern between children or between staff and children/youth.

FAMILY CONTACT/FAMILY ENGAGEMENT

¹⁵³ Id. at 9.

¹⁵⁴ United States Department of Education, “*Readiness and Emergency Management for Schools Technical Assistance Center: Educator Sexual Misconduct, What School Staff Need to Know and Do*”, Vol. 3 Issue 2 (2008), available on the web at: https://rems.ed.gov/docs/HH_Vol3Issue2.pdf.

All facilities should consider how to strengthen youth's ties to their families and community institutions while the youth is in secure care. The Department of Justice's OJJDP Policy Guidance includes numerous recommended "focus areas" for states and local communities, some excerpted below with additional recommendations from OCA:

1. Facility staff should receive specific training in effective youth and family partnership and engagement strategies.
2. Facilities should allow developmentally healthy and appropriate activities and recreation for youth and family members during visitation to strengthen family bonds and minimize the trauma of separation.
3. All youth-serving facilities should be required to permit contact visits with youth unless a timely and specific risk assessment tool determines that the provision of a contact visit creates a risk of imminent harm to the youth or others.
4. All youth-serving facilities must have strategies to support therapeutic family engagement as either part of a treatment model, where applicable, or part of a discharge planning process.
5. All youth-serving facilities should be required to collect data and report regarding the efficacy of its family engagement and visitation policies and practices.
6. Advisory group membership/s should include current and former system-involved youth and their families.